DOCUMENT RESUME

ED 476 235 PS 031 111

AUTHOR	Fenichel, Emily, Ed.
TITLE	Agents of Change in Foster Care for Infants and Toddlers.
INSTITUTION	Zero to Three: National Center for Infants, Toddlers and Families, Washington, DC.
ISSN	ISSN-0736-8038
PUB DATE	2002-05-00
NOTE	70p.; Published bi-monthly.
AVAILABLE FROM	Zero to Three, % SunTrust Bank, P.O. Box 79768, Baltimore, MD 21279-0768 ($60, one-year subscription, 6 issues). Tel: 800-899-4301 (Toll Free); Tel: 202-638-0840; Fax: 202-638-0851; e-mail: orders@zerotothree.org; Web site: http://www.zerotothree.org.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Zero to Three; v22 n5 Apr/May 2002
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS
DESCRIPTORS	Attachment Behavior; Biological Parents; *Change Agents; *Change Strategies; Child Advocacy; Child Health; Childhood Needs; Court Litigation; Emotional Adjustment; Family (Sociological Unit); *Foster Care; Foster Children; Foster Family; *Infants; Intervention; Mental Health; Parent Child Relationship; Program Improvement; Public Policy; Social Services; *Toddlers

ABSTRACT

"Zero to Three" is a single-focus bulletin of the National Center for Infants, Toddlers, and Families providing insight from multiple disciplines on the development of infants, toddlers, and their families. Conceived by the Zero to Three Child Welfare Task Force, this issue focuses on agents of change for infants and toddlers in foster care-individuals, programs, institutions, and systems that are concerned with the growing numbers of very young children in the foster care system and their distinct, though often unrecognized, vulnerability. The featured articles in this issue are as follows: (1) "Ambiguous Outcomes, Imperfect Tools: Challenges in Intervention with Young Children in Foster Care and Their Families" (Alicia F. Lieberman); (2) "Attachment and Biobehavioral Catch-Up: The ABC's of Helping Infants in Foster Care Cope with Early Adversity" (Mary Dozier, Deane Dozier, and Melissa Manni); (3) "Babies in Foster Care: The Numbers Call for Attention" (Fred Wulczyn and Kristen B. Hislop); (4) "Treating Infant-Parent Relationships in the Context of Maltreatment: Repairing Ruptures of Trust" (Julie A. Larrieu); (5) "Sharing Child Development Expertise in Court: Respect, Rules and Roles" (Martha Grace, Cindy S. Lederman, and Joy D. Osofsky); (6) "Building a Pathway of Well-Being: The Story of the 'Healthy Development Checklist for Children in Foster Care'" (Sheryl Dicker and Elysa Gordon); (7) "Providing Mental Health Services to Young Children in Foster Care: A Family-by Family, Moment-by-Moment Approach to Change" (Elaine Groppenbacher, Cynthia Hoard, and Sandie Miller); (8) "Working toward Relationship-Based Child Welfare Practice: The SEED Model after 5 Years" (Kathryn Orfirer and Diana Kronstadt); (9) "The Accidental Advocate: Moving from Individual Case Advocacy to System Change" (Judith A. Silver); (10) "Play and Learn at Our Place" (Randy Lee Comfort); and (11) "Intervening with Young Children in Foster Care: Using Countertransference Reactions to Facilitate the Therapeutic Process" (Theresa Jacobsen). Regular departments of the bulletin list Zero to Three publications, videotapes, and on-line

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ZERO TO THREE®

April/May 2002
Volume 22 No. 5

Bulletin of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Agents of Change in Foster Care

For Infants and Toddlers

New intervention approaches with children, families, and foster parents

Protecting the healthy development of young children in foster care

Bringing child development expertise to court

Studies in systems change

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EDITOR'S NOTE

This issue of *Zero to Three* is about agents of change for infants and toddlers in foster care – individuals, programs, institutions, and systems that are concerned with the growing numbers of very young children in the foster care system and their distinct, though often unrecognized, vulnerability. It was conceived by ZERO TO THREE's Child Welfare Task Force, chaired by **Megan Gunnar** of the Institute of Child Development at the University of Minnesota, with **Julie Cohen** as staff lead, and members **Martha Grace, Diana Kronstadt, Cindy Lederman, Alicia Lieberman,** and **Judith Silver**, many of whom have contributed to this issue. The contributors to this issue represent the worlds of epidemiological and intervention research, the judicial system, and clinicians working in a range of settings.

Alicia Lieberman's opening essay recognizes the difficult choices and ambiguous outcomes that accompany even intensive collaboration on a young child's behalf. **Fred Wulczyn** and **Kristen Hislop** succinctly marshal crucial data that make the epidemiological case for increased attention to infants, especially the youngest babies, and toddlers who are entering foster care. **Mary Dozier, Deane Dozier,** and **Melissa Manni** report on research concerning the attachments of infants and toddlers in foster care and a multipronged intervention approach designed to help foster parents encourage healthier emotional development among the children in their care. **Julie Larrieu** discusses the treatment of parent-infant relationships in the context of a program designed to provide Child Protective Services personnel and the Juvenile Court with information to guide their decision making – an effort that substantially reduces the risk of future maltreatment.

Many agents of change are operating within the judicial system, as judges, attorneys, and others work with child health and development specialists to secure health, developmental, and mental health services for young children in foster care, as well as to make informed decisions about their overall care. **Sheryl Dicker** and **Elysa Gordon** describe one such effort, the development and use of the New York State Permanent Judicial Commission on Justice for Children's "Checklist for the Healthy Development of Foster Children." Judges **Martha Grace** and **Cindy Lederman** and psychologist **Joy Osofsky** provide guidance about how to provide meaningful information effectively in the court environment.

Some agents of change for infants and toddlers in foster care develop their approaches gradually, building relationships with partners and taking advantage of available opportunities. **Elaine Groppenbacher, Cynthia Hoard,** and **Sandie Miller** describe the growth of their Good Fit center's mental health services to young children and their foster or adoptive families in the context of Arizona's managed behavioral health care system. **Judith Silver** chronicles the process by which concerned clinicians in Philadelphia's Starting Young initiative have become community activists, coalition builders, and partners in systems change. Some, like Oakland, California's SEED Project (described by **Kathryn Ofirer** and **Diana Kronstadt**), are designed as collaborations toward systems change from the beginning and refine their models as they learn from experience.

Randy Comfort has changed the support system available to foster and adoptive parents in Bristol, England by establishing a "Play and Learn" program for infants and toddlers uniquely adapted to their needs. **Teresa Jacobsen**'s description of the intense feelings evoked in therapists by young children who have experienced multiple placements remind us of the importance of intervening as early as possible to ensure security, stability, and nurturance for infants and toddlers in foster care.

The multifaceted nature of the articles reflects the multidimensional nature of the problems and potential paths toward solutions for very young children caught up in the foster care system. As opportunities expand to serve these infants and toddlers, through Early Head Start and other initiatives, we hope that many more people will be empowered to become agents for infants and toddlers in the foster care system.

Emily Fenichel

ZERO TO THREE

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ISSN 0736-8038
©2002 ZERO TO THREE: National Center for Infants, Toddlers, and Families
2000 M Street, NW, Suite 200
Washington, D.C. 20036-3307
Tel: (202) 638-1144
Customer Service: 1-800-899-4301
www.zerotothree.org

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AMBIGUOUS OUTCOMES, IMPERFECT TOOLS:

Challenges in Intervention With Young Children in Foster Care and Their Families

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Those of us who are immersed in the often-intractable dilemmas presented by foster care seldom speak confidently about sweeping solutions. We know that unambiguously happy endings are quite rare, and we also know that, much too often, events have proven us wrong in the long run when we made recommendations that we thought to be in the best interest of the child given the information available to us at the time. The story I am about to tell* illustrates the multiplicity of challenges in intervention with children who are in foster care and their families.

In the unfolding of this story, I played a dual role. First, I provided consultation about decision making to the child welfare worker in my role of mental health consultant to the San Francisco Child Protection Services (CPS). Later, I was the clinical supervisor for the therapist who provided infant-parent psychotherapy to the child and his mother.

Andrew and Amelia

Andrew was 2½ years old when his CPS worker brought him to my attention. He was living in Austin, Texas, where his 25-year-old mother, Amelia, had left him 10 months earlier, when he was about 20 months old, saying that she would be back for him in a few days. She had not returned, and the aunt with whom Amelia and Andrew had been staying contacted CPS, saying that she was unable to take care of the child. Andrew then began the customary cycle of short-lived foster care placements that is the norm for children in the child protection system. In the course of 10 months, he was in three foster homes, so that by the time his child welfare worker and I discussed his case, he had had at least four caregiver losses we knew about: his mother, his grand-aunt, and the two foster homes prior to his present one. Moreover, his current foster mother did not want to keep him on a permanent basis, so it was only a matter of time until another change of caregiver had to occur.

We don't know why the Austin CPS system did not start a search for an adoptive home when Andrew's mother disappeared. It was probably because he was little and his CPS worker, most likely overworked and undertrained about the emotional needs of babies, figured that he was young enough that he could wait while more urgent cases were dealt with. I have often heard a variety of professionals involved in the

* All identifying details have been changed to protect confidentiality.

foster care system say that "if a baby can get attached once, he can form a new attachment if the first one has to be broken." In this way, the developmental plasticity of babies and toddlers is used against them to justify the absence of timely intervention. For Andrew, the result of this pervasive attitude is that by the time he was 2½ years old, there was nobody looking out for his long-term well-being.

At about that time, Andrew's mother, Amelia, resurfaced in San Francisco and contacted the local CPS to request reunification with her child. Amelia had been living in San Francisco for the past 6 months with a 30-year-old man and his family, a working class couple who had taken her under their wing. He worked only sporadically due to a physical disability for which he received SSI. Amelia was also on SSI, but the reasons for this were unclear. Amelia told the San Francisco CPS worker that, for the first time in many years, she had stable housing and was able to offer a home to her child. The CPS worker visited the home, met Amelia, the boyfriend, and his parents, and thought that the idea of reunification had some merit. She was particularly impressed by the mother's commitment to reunification and her willingness to do anything that was asked of her to make it come about. At the same time, she worried about the long time that had transpired without this mother making contact with her child, about the newness of Amelia's relationship with her boyfriend and his family, and about the stresses that a toddler would place on the new family constellation this mother had managed to assemble for herself after spending many years in the foster care system herself. In the meantime, Andrew was in limbo in Austin. It was only a matter of time until another placement would need to be found for him.

The Choices Available

During our consultation session, the San Francisco CPS worker and I weighed the choices available to us. We believed that, given Amelia's history of abandoning her child and disappearing and the concerns about her emotional stability raised by the CPS record, a solid and loving adoptive home would be the safest bet for Andrew's long-term stability. What were the chances of finding such a home? The CPS worker told me that the first step would be to bring Andrew to San Francisco, place him in a temporary foster home, and then start the search. In the meantime, his mother would be legally entitled to reunification services, so that visitations between mother and son would need to be arranged.

As we sorted out what we believed was best for Andrew and what we knew was possible given the legal protections for biological parents and the delays imposed by a cumbersome bureaucracy, the CPS worker and I came to the conclusion that, in the context of Amelia's apparent commitment to reunify with her son, it would be safer to do our best to increase the chances of a successful reunification. Our decision came to a question of logistics. If we opted to pursue adoption, it would take at least 6 months to locate a family, and there was no guarantee that the family would be in the Bay Area. By this time, Andrew would be at least 3 years old. In addition, Andrew would need to acquaint himself with the "fost-opt" parents prior to placement with them while simultaneously having reunification visits with his mother and adjusting to his new San Francisco foster home. We also worried that he might have to move from an adoptive home to Amelia's home if the Court found that in the interim his mother had fulfilled the legal requirements for reunification. With a mother who was present, willing, and able to take care of her child, our chances of persuading the Court that adoption was the preferred course of action were almost nonexistent.

Who Is Amelia?

Of course, reunification hinged on Amelia's capacity to take care of Andrew. The CPS worker and I decided that a psychological evaluation was in order to determine her mental health status. This evaluation confirmed something that we already knew: Amelia tended to distort reality in wishful ways. She said, for example, that she called her son regularly while she was apart from him and that she had visited him twice during their separation. There was no evidence for any of this in the Austin CPS records. She also said that her aunt in Austin saw Andrew regularly and kept her informed about him. There was no evidence to support this assertion either. On the other hand, the assessor could find no specific diagnosis that fit Amelia: she was not psychotic; she was not clinically depressed; she did not have schizoid features; she had no severe anxieties.

Amelia's distortions of reality were circumscribed to topics that, if we believed her version of things, would give her a better chance of getting her son back. Perhaps she was lying to make herself look better. Perhaps she needed to create a self-protective image of herself as an available mother. Perhaps, as she claimed, the Austin CPS records were incomplete. In other areas, the CPS worker found a marked discrepancy between the psychological evaluator's description of this mother and her own experience of her during several lengthy meetings. The evaluator found Amelia to be "characterologically flawed" in unspecifiable ways. The CPS

at a glance

- Misunderstandings about attachment are frequent in the foster care system.
- Working together, Child Protective Service workers and mental health consultants can assess options from the perspective of a child's long-term well-being.
- Sensitive foster parents, as well as child-parent psychotherapists, can support parents working toward reunification.
- Even when everyone tries to do their best for a child, outcomes can be unsettlingly ambiguous.

worker found her to be a young woman with a tough past desperately searching for stability.

As a mental health consultant with no direct access to any of the main characters in this drama, I found it very difficult to be self-assured in my recommendations of what course to take. After much thought, the CPS worker and I agreed that she would ask the Adoption Unit to start searching for a potential adoptive family for Andrew, but in the meantime we would refer Andrew and his mother to an infancy and early childhood mental health program to help Andrew in his transition from his Austin home to his new San Francisco foster placement, and to help Andrew and his mother rebuild a relationship with each other.

As a supervisor to the clinical treatment, I could appreciate the difficulties posed by reunification. Andrew was a bewildered little boy with a classic DSM-IV diagnosis of Reactive Attachment Disorder: He was indiscriminate in his social relationships, called every female "Mommy," and seemed emotionally disconnected from the people around him. His anxieties came out suddenly and unexpectedly, as he hit people out of the blue and banged his head at the slightest provocation.

Child-Parent Psychotherapy

The child-parent psychotherapy lasted 1 year and focused on helping Andrew and Amelia understand the child's behavior as an expression of his feelings about losing his mother, being adrift for a long time, and then finding her again but being uncertain that this time the reunion would last. It also focused on Amelia's understandable ambivalence about having her freedom curtailed by the needs of an intense and demanding little boy for whom she also felt a strong sense of commitment.

The therapist's work was aided by a fortunate circumstance. Andrew had been placed in San Francisco with a warm and caring foster mother who had an intuitive appreciation of this little boy's predicament. The foster mother was supportive of Amelia's wish to reunify, and invariably spent time with Amelia and Andrew during the visits to facilitate the transitions. The child-parent psychotherapist supported and facilitated this communication between the two women. Also, to Amelia's credit, she was able to rely on the foster mother's input and advice, and spoke nicely about her to Andrew. Nevertheless, the reunification process was emotionally trying on everybody, as the therapist observed Andrew's increasing difficulty separating from his foster mother, his lukewarm interest in his biological mother, and Amelia's emotional fluctuations between empathy, irritation, and authoritarian discipline when she felt disregarded and disrespected by her child.

Perhaps for the better, the reunification process had to be accelerated when the foster mother's husband became gravely ill and the couple decided to move out of state to be closer to their adult children.

Ambiguous Outcomes, Ongoing Efforts

Without describing the details of the reunification process, let me note that 6 months after the termination of child-parent treatment, Amelia continues to be committed to her child and has worked hard to find a good school for him. At the same time, she continues to find Andrew quite difficult and believes that he needs medication to help him regulate his tantrums. At age 4, he has begun individual psychotherapy and we hope that his therapist will provide ample collateral support to his mother.

The saga of Andrew and Amelia is an ongoing one that illustrates how, even in the absence of dramatic incidents of abuse or blatant psychopathology, and even when everybody tries to do their best for the child, the outcome can be unsettlingly ambiguous. I often ask myself whether in my role as CPS mental health consultant I should have insisted on adoption as the best course of action for Andrew. However, my self-reproach is moderated by first-hand knowledge of how often adoptive placements fail, and by knowledge about the Court's continuing propensity, in spite of the legal changes favoring adoption, to give biological parents preference in making custody decisions for a child.

We want to create a safer, more predictable, and more consistently nurturing world for vulnerable young children and families — within and beyond the foster care system.

For me, the story of Andrew and Amelia stands as an example of the gray coloring of so many CPS cases. It is hard to know whether there is an absolute truth, and if so, what it consists of. It is also hard to know what the facts are. When is a mother's psychopathology so serious as to render her unable to parent? Is a psychological assessment a valid instrument in itself? Are the observations of the CPS worker biased or based on insufficient clinical training? Would a different child-parent psychotherapist have attained a more successful outcome? Would a more effective clinical supervisor have brought about a more successful therapeutic outcome?

We want to create a safer, more predictable, and more consistently nurturing world for vulnerable young children and families — within and beyond the foster care system. We only have ourselves as imperfect tools to use in the work of helping children and families, and improving our communities' systems of care. Yet across the country, people who work with young children in foster care and their families are striving to make the tools at our disposal – namely, ourselves — less imperfect and more effective in this endeavor. And we will stay on the job.

Attachment and Biobehavioral Catch-Up:

The ABC's of Helping Infants in Foster Care Cope With Early Adversity

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Photo: Marilyn Nolt

Maurice is 12 months old and a candidate for a foster home. After several failed attempts by his mother to curb her substance abuse, beginning from the time she first realized she was pregnant, she finally gave in to the grandmother's offer to take the child. But the grandmother's emphysema grew steadily worse. Finally, the strain of tending to the needs of an infant proved to be too much for her, too. Maurice had hardly learned to say "mama" when his grandmother asked the Division of Family Services to find another home for him.

Esther was just 2 months old when she was taken from her birth mother and placed in a foster home where there are three other children. Her foster mother makes sure Esther is clean, clothed, and fed, but her other children and the sewing she takes in to help pay the bills leave her little time to interact with the new baby. Although she finds Esther's quietness a bit strange, she has to admit to a certain relief that the child's complacency and lack of fussiness mean fewer demands on her limited time.

Clarence's new foster mother is delighted to find herself with a 16-month-old now that her own babies are grown. At first, the baby doesn't respond to the mother's cooing and cuddling, pushing her away at times. Over time, however, her loving attempts are rewarded with his looking to her when he is upset. He even begins to call out "Mama" when a stranger enters the house, and moves quickly to her side. To her surprise, she finds that she wants to adopt Clarence. Over the next 2 years, Clarence's paternal grandmother comes into the picture and seeks custody. As Clarence goes for overnight visits with the grandmother, his foster mother feels a panic over losing him that she had never before known. Eventually, when Clarence is 4, the grandmother recedes into the background, and he is adopted by his foster mother.

As different as these examples are from one another, each of these children has had to cope with early inadequate care, as well as disruption in the primary attachment relationship. These conditions present enormous challenges for young children. Children develop strategies for coping with these

at a glance

- This article represents an overview of 10 years of research on how children cope with disruptions in care.
- Children placed in foster care often behave in ways that suggest that caregivers are not needed.
- For foster parents to provide nurturing care to children, they must see the neediness underlying children's behavior.
- Our Attachment and Biobehavioral Catch-Up intervention addresses the child's failure to elicit nurturance, caregiver discomfort in providing nurturance, and behavioral and biobehavioral dysregulation in children.

conditions that, however adaptive in the short-term, often fail to serve the children well in subsequent relationships.

Infants' attachment to caregivers is not hard to understand when we consider the role that dependence on the caregiver has played in evolution. The attachment system evolved to maximize the likelihood that infants survive and pass on their genes. By the time babies are physically able to crawl or walk away from the parent, they have developed attachments such that they stay close enough to allow a quick return when they feel threatened. Left to their own devices, infants are not likely to be caught far away from parents in potentially threatening conditions such as at nighttime, when strangers are present, and in illness.

When caregivers are neglectful or abusive or when the relationship is disrupted (through death or foster care placement, for example), the system cannot function as intended. We propose here that the failure of this system to function as biologically intended is a profound one, with potential impacts across a range of behavioral and biological systems. Nurturing, responsive care provided by foster parents, though, may provide children with the resources they need to cope adequately with this failure.

In the past 10 years, we have been studying how children cope with disruptions in care. On the basis of our findings, we have developed an intervention that targets the three needs we have identified as being critical. This article presents an overview of our research findings and a description of the Attachment and Biobehavioral Catch-Up (ABC) Intervention.

Initial Adaptation to Foster Care Placement

When children are first placed into foster care, they often behave in ways that suggest that caregivers are not needed. For example, when Maurice fell down and hurt himself, he whimpered and sat alone, hugging himself, even though his mother called his name and said, "oh, poor baby." When Esther became frightened of a dog barking, she backed into a corner of the yard rather than run into her foster mother's arms.

We developed a diary methodology that allowed us to study how children developed attachments to foster parents in the first weeks and months of placement (Dozier & Stovall, 1997). Foster mothers were asked to indicate how their child responded to three incidences of distress each day, including when the child was hurt, frightened, and separated from the parent. Foster mothers completed a checklist and a narrative account for each incident describing the child's behavior, the foster mother's response, and the child's subsequent response. Child behaviors and maternal behaviors were then coded (child behaviors were coded as proximity seeking, avoidant, or resistant; parent responses were coded as nurturing, rejecting/passive, or rejecting/active).

For 38 foster children, foster mothers completed the diaries for 60 consecutive days beginning in the first or second week of the child's placement in the home. Children placed prior to 8 to 10 months of age typically readily showed secure behaviors (i.e., proximity seeking and calming) when placed with nurturing caregivers. However, children placed after about 10 months of age often behaved in avoidant or resistant ways when distressed (Stovall & Dozier, 2000; Stovall & Dozier, 2002). These insecure behaviors persisted throughout much of the 2-month period observed.

Just as important, babies' behaviors elicited complementary behaviors from their caregivers. Examining the contingency between a child's behavior and the caregiver's response, we found that secure infant behavior was followed reliably by nurturing parental behavior; avoidant child behavior was followed reliably by the caregiver behaving as if the child did not need her; and, resistant child behavior was followed reliably by "fussy" caregiver behavior.

If foster parents are to provide nurturing care to their children, they must re-interpret children's behavioral signals. It is critical that they see the neediness underlying children's behaviors, and respond to this underlying message. The first component of our ABC Intervention program addresses this issue. As presented more fully when we describe our intervention later in this article, foster parents are helped to see that children need them, regardless of how much they might appear not to need them.

The Consolidated Attachment With New Caregivers

The behaviors that babies show when they are distressed reflect the quality of their attachments to parents. Among "typical" parents and infants (i.e., those not in the foster care system), children develop expectations based on a long history of interactions with parents. One can then "see" these expectations as children behave in characteristically different fashions when they are distressed. We first describe these patterns seen among typical parents and infants before describing what we have found among foster infants and their caregivers.

Secure attachment. If children come to expect that their mothers will be there when needed, they tend to develop secure attachments. We can see this secure attachment in the child's going to the mother for comfort when scared, concerned, hungry, or sick, for example. What differentiates

these children from children with insecure attachments is not how hard they cry when they are upset, or how long it takes them to settle down, but rather their ability to use their parent to help them settle down.

Mothers of children with secure attachments are usually coherent in the way they talk about their own attachment figures and attachment experiences (van Ijzendoorn, 1995). They are neither caught up in earlier conflicts, nor do they try to distance themselves from attachment issues. Rather, they are able to talk coherently about attachment issues. Mary Main and her colleagues have developed an interview in which parents are asked about their attachment experiences (George, Kaplan, & Main, 1984). Parents are classified as having "autonomous states of mind" when they are open and coherent in their description of attachment issues.

Avoidant attachment. When children come to expect that their mothers will not be there when needed, they develop insecure attachments. Children whose mothers are rejecting of their bids for reassurance tend to develop avoidant attachments. There are a number of ways parents might be rejecting. Take, for example, a boy who falls off a chair and comes crying to his mother. Rather than hug the child, one mother says, "Look at the bird in the tree"; another mother says, "You're a big boy, you don't need to cry"; whereas still a third says, "I told you not to get up on that chair." In all three instances, the child has gotten the message that he will not be reassured when hurt. If this characterizes the mother's usual response to the child, the child will then develop the expectation that the mother will not be available when he is distressed. Such children tend to develop avoidant attachments. For example, they may first look to the parent and then turn abruptly away (seeming to remember that they should not look to the parent for reassurance), or may just appear indifferent to the parent's presence. This strategy makes sense, and can be seen as adaptive with this parent – the child is asking no more of the parent than the parent is willing to give.

Mothers of children with avoidant attachments are often dismissing or devaluing of their own attachment experiences (Main & Solomon, 1990). When asked to talk about attachment figures, they may describe them in idealized ways. For example, they may characterize parents as "wonderful and loving," but may not be able to instantiate the description with specific examples. Thus, there is a not quite "real" quality to their glowing characterizations. Also, these mothers are often limited in their recall of specific incidences of distress when they were young. In general, they are not comfortable thinking through challenging attachment issues or in considering the impact of attachment on current functioning. The discomfort these mothers experience may make it difficult for them to deal with their children's distress. These mothers are said to have "dismissing states of mind" with regard to attachment.

Resistant attachment. When parents are inconsistent in responding to their children's distress, children are left not knowing whether their needs will be attended to or not. These children often develop resistant attachments to their parents, behaving in fussy and inconsolable ways when upset. They appear to want contact with their parents, yet resist that contact. As with avoidant attachment, these behaviors can be seen as adaptive — the child asks for reassurance frequently from a parent who gives it only intermittently.

Mothers of children with resistant attachments are often caught up in their own attachment issues. During the attachment interview, they may angrily report events from the past as if they were current, or ramble from one topic to another without being able to focus clearly on the issue at hand. These mothers' preoccupation with their own attachment issues may interfere with their ability to respond consistently to their children's needs. These mothers are said to have "preoccupied states of mind" with regard to attachment.

Disorganized attachment. When caregivers behave in frightening ways to children, children are most likely to show a breakdown in attachment strategy when they are distressed and in their parents' presence. According to Mary Main, these children seem to have an irreconcilable dilemma – they are frightened of the person to whom they look for reassurance (Main & Solomon, 1990). Parents may be frightening to children in a variety of ways – certainly one way is through actually harming or threatening to harm the child. But children can also be frightened of parents who threaten to leave them, who play in a too-threatening fashion, or who treat the child as if the child were frightening. Children with disorganized attachments can show a range of behaviors, such as entering trance-like states when distressed, moving away from the parent when distressed, or showing an odd combination of behaviors that do not serve a clear goal.

Parents of children with disorganized attachments often have a loss or abuse in their own past that they have not worked through fully. This previous trauma appears to lead the parent to act in ways that are either frightening (e.g., scaring the child) or frightened (e.g., treating child as if he or she could hurt the parent). These mothers are said to be "unresolved" with regard to attachment.

Although some attachment theorists and researchers may take issue with us, we suggest that it is disorganized attachment that confers the most significant risk for later psychopathology. Whereas it might be optimal that children develop secure attachments, children with avoidant and resistant attachments have strategies that are well suited to their caregivers. Such insecurely attached children are at somewhat increased risk for anxiety disorders (Warren, Huston, Egeland & Sroufe, 1997), and for somewhat less optimal outcomes with teachers and peers (e.g., Elicker, Englund & Sroufe, 1992). Nonetheless, we suggest that the risk for psychopathology associated with avoidant or resistant attachment is not especially high. On the other hand, disorganized attachment is associated with a range of later problems, including especially dissociative symptoms (e.g., child seeming to be "in a fog," "out of it," or detached) (Carlson, 1998), but also internalizing symptoms (e.g., depressive and anxiety) and externalizing symptoms (e.g., acting out)

(Lyons-Ruth, 1996; Lyons-Ruth, Alpern, & Repacholi, 1993). Therefore, it is disorganized attachment that we want to work especially hard to remediate.

Foster children's attachments. There are several reasons why we might expect foster children to have difficulty forming secure attachments with their new foster parents. These children have often experienced compromised prenatal environments, they may have been abused or neglected, and they suffered a disruption in their primary relationships. In addition, our diary data indicate that these children often behave in ways that push caregivers away.

The quality of the child's attachment to the caregiver was assessed using the Strange Situation after children had been in their foster homes at least 3 months. The Strange Situation is a standard procedure used for assessing attachment (Ainsworth, Blehar, Waters, & Wall, 1978). Foster mothers were given the Adult Attachment Interview (George et al., 1984) to assess their state of mind with regard to attachment. We assessed the association between maternal state of mind and child attachment among 50 foster care dyads.

To our surprise, attachment state of mind predicted child attachment at nearly the same level as among birth parents and children (Dozier, Albus, Stovall & Bates, 2001). Most children (68%) placed with autonomous caregivers formed secure attachments with their caregivers, and most children (81%) placed with non-autonomous caregivers formed insecure attachments. This was seen regardless of when children were placed into care; even children placed as late as 20 months of age developed secure attachments with autonomous caregivers.

That children placed with autonomous caregivers were likely to form secure attachments was surely good news. However, our data also provided some bad news. When foster children were placed with non-autonomous caregivers, they were likely to form disorganized attachments at very high rates. Indeed, 72% of children placed with non-autonomous caregivers formed disorganized attachments. It did not matter whether children were placed with dismissing or unresolved caregivers; in either case they were very likely to form disorganized attachments. We suggest that foster children cannot develop organized attachment strategies unless they have nurturing (i.e., autonomous) caregivers. Thus, it is critical that foster parents are nurturing, or at least that they learn to respond to their foster children's bids for distress in nurturing ways.

The second component of our intervention program targets foster parent nurturance. Foster parents are encouraged to look at their own issues that might interfere with their providing sensitive, nurturing care. They are urged to consider how essential nurturance is for foster children – even if their own children could adapt to non-nurturing care, foster children require nurturance if they are to thrive.

Regulation of Physiological Systems

When we found that more than half of the foster children had developed secure attachments to their new caregivers, we considered several possibilities. On the one hand, it was possible that these children were thriving. On the other hand, it was plausible that many children were dysregulated at more somatic or physiological levels.

Although behavior and physiology often provide converging evidence, there are important exceptions. When infant monkeys are separated from their mothers, their production of the stress hormone cortisol continues to climb even after their crying drops off (Levine, Wiener, & Coe, 1993). If only the behaviors of these monkeys were considered, one might incorrectly assume that the monkeys were no longer upset by the separation. When considering hormone levels, however, it is possible to see that the separation is affecting these infant monkeys. We thought that effects of early inadequate care could perhaps be seen at the neuroendocrine level even if not at the behavioral level.

The HPA (hypothalamus-pituitary-adrenal) system is very reactive to adverse early experience. The hormone cortisol is the end product of the HPA system. The hypothalamus responds to input from the limbic system, and sends endocrine messages to the pituitary. The pituitary sends endocrine messages to the adrenal cortex, which then secretes glucocorticoids (cortisol in primates, and cortisone in rodents). Because cortisol is sequestered in saliva, levels can be measured rather unobtrusively.

We examined cortisol levels among 40 foster children and 25 control children three times daily (wake-up, afternoon, and bedtime) over a 3-day period (Dozier, Levine, Eldreth, & Stovall-McClough, 2001). To create a more reliable measure of levels across the day, we averaged across the 3 days for each time of day. Foster children more frequently showed "atypical" patterns of cortisol production when compared with other children. Most foster children showed low levels, especially in the morning, compared with other children, although some showed extremely high levels. Even after 2 to 3 years in a foster home, children continued to show unusual levels of cortisol production. In that the HPA system is so basic to survival and develops so early, these findings are striking.

To develop an intervention component to help children develop better physiological regulation, we went for guidance to interventions that targeted behavioral and physiological dysregulation among premature infants and temperamentally difficult infants (Barnard, 1999; Barnard & Morisset, 1995; van den Boom, 1994, 1995). Although these interventions have focused on the needs of infants who are vulnerable as the result of prenatal and perinatal insults or temperamental vulnerabilities, the challenges seemed similar. The focus of such interventions has been in helping infants and young children gain a sense of effectance. It is thought that, for the poorly regulated young child, the experience of having a predictable, responsive interpersonal world helps in the development of behavioral, emotional, and physiological regulation. Therefore,

our third intervention component helps foster parents to become very responsive interpersonal partners allowing the child to become an effective leader in interactions.

Attachment and Biobehavioral Catch-Up: The ABC Intervention

We have argued that children entering foster care have several very specific needs. First, as the result of separations from caregivers, foster infants often behave in ways that fail to elicit nurturance from their new caregivers. Foster parents need to learn to reinterpret children's rejecting signals and provide nurturance to these children, even though the children may not appear to need nurturance. Second, some caregivers are not comfortable providing nurturance to distressed children. Children who have experienced relationship disruption, however, need nurturing care if they are to develop organized strategies for coping with negative affect. Surrogate caregivers who do not respond in nurturing ways need to learn new strategies for reacting to their foster children's distress. Third, these children often show unusual, or atypical, patterns of neuroendocrine regulation. Caregivers need to provide a predictable environment for the child, and a world that is particularly responsive to the child's signals. We have brought together several intervention components in the ABC Intervention that address these three targeted issues for infants and toddlers entering foster care.

Component A: Child failure to elicit nurturance. The first treatment component of the ABC Intervention focuses upon the caregiver's need to recognize that the child needs her, regardless of whether the child communicates that need clearly. Foster parents are taught to see children's behaviors that might otherwise alienate them as reflecting children's strategies for coping with previous relationship failures. Caregivers are then urged to recognize that all children need nurturance, even though some may not show that need directly. Caregivers then learn skills for providing nurturance even when children fail to ask for reassurance or spurn their efforts.

Component B: Caregiver discomfort in providing nurturance. Some caregivers are not comfortable providing nurturance to distressed children. Interventions targeting caregivers' difficulties in providing nurturance have resulted in positive outcomes for children and caregivers (e.g., Lieberman, 1985; Lieberman, Weston, & Pawl, 1991). Lieberman's intervention for non-nurturing mothers focuses upon ways in which the mother's own issues interfere with her ability to provide nurturance. This intervention has proven effective in helping caregivers become more responsive to their children's distress, and in helping children develop more trusting relationships with their caregivers. We have adapted this intervention to be appropriate for a time-limited context, with attention to caregivers' own issues that interfere with providing nurturing care in each session.

Component C: Behavioral, emotional, and neuroendocrine dysregulation. Interventions targeting dysregulation at behavioral and biobehavioral levels have been developed for caregivers of premature infants (Barnard, 1999; Barnard & Morisset, 1995), as well as temperamentally "difficult" infants (van den Boom, 1994, 1995). The focus of these interventions has been to help infants, toddlers, and young children experience mastery or effectance in their worlds. Presumably, for the poorly regulated young child, the experience of having a predictable, responsive interpersonal world promotes the ability to develop behavioral, emotional, and physiological regulation.

Currently we are assessing the efficacy of the ABC Intervention in a randomized clinical trial funded by the National Institute of Mental Health. All foster parents in northern Delaware who have infants placed with them will be randomly assigned to the ABC Intervention described below, or to a control intervention of comparable length. We expect that foster parents who receive the ABC Intervention will become more nurturing of their children, and will become more responsive play partners compared with foster parents who receive the educational intervention. We expect that their children will develop organized attachment strategies at a higher rate, and better self-regulatory capabilities, compared with children whose foster parents receive the control intervention.

The advantage of using a randomized clinical trial design is that it allows us to have confidence that differences that emerge are the result of the interventions themselves, and not the result of other factors. If we were to assess outcomes without using a control group, it would be difficult to know whether changes from pre- to post-intervention reflected changes that would have occurred anyway. Similarly, if we were to assess outcomes relative to a no-treatment control group, superior outcomes for the experimental treatment could be the result of placebo effects (e.g., foster parents in the intervention group may have expected that they would have better outcomes). And, if we were to assess outcomes without the use of random assignment to treatment condition, differences could be the result of confounding variables (e.g., differences in which foster children were assigned to the two interventions).

How the Intervention Works

Ten sessions, each lasting about an hour, are conducted in the home of the caregiver. Although the intervention is designed for the parents of children between 10 and 24 months of age, it can be modified to be appropriate for parents of younger children.

Specifically, the caregiver learns to interact with the foster child during the 10 sessions in this progression:

Session 1: Introduction to key concepts. The trainer explains the primary objectives of the training with the foster parent. The trainer discusses how important it is for the caregiver to develop a nurturing relationship with their foster child, and the reasons that children need to have a relationship that is predictable and responsive to their needs, even when children have difficulty showing those needs. As homework, the parent keeps a diary of how the child

responds when distressed.

Session 2: Providing nurturance. What about the child makes it difficult? The focus in Session 2 is on helping the foster parent see the child's behavior in a new light, and on developing more nurturing ways to respond when the child is distressed. The trainer reviews the diary of the child's behavior with the caregiver, carefully studying how the child acted when upset. Any secure behaviors, where the child clearly indicated his or her needs, are discussed, along with the response the behavior drew from the caregiver. In cases where the child seemed to avoid or resist the caregiver's attempts to nurture him or her, the trainer helps the foster parent see the necessity of taking the lead and looking beyond the child's behavior to the hidden needs. It is vitally important in such cases that the caregiver learn to respond to needs she cannot see.

Sessions 3 and 4: Providing nurturance—Recognizing "shark music." Sessions 3 and 4 address difficulties the caregiver herself may have that interfere with her ability to sense her child's distress or to respond in positive ways to the child's needs. The trainer helps the foster mother through the somewhat sensitive task of exploring how her own attachment issues may affect her parenting. To help the foster parent learn to recognize her own issues that may throw up roadblocks in responding positively to her child, the trainer employs the metaphor of shark music that was developed by Cooper and colleagues (2000). After first viewing a video of the ocean accompanied by peaceful soothing music, the caregiver then watches the same video accompanied by the music from the movie "Jaws." She learns that all parents hear "shark music" at times. Indeed, the key to successful parenting lies in recognizing one's own shark music, then taking control of responses to the child.

After the shark music metaphor is introduced, the foster mother thinks about her instinctive reaction when her child needs nurturing. The trainer discusses the reactions to the child's signals in very concrete terms so the foster mother becomes aware of the words that go through her mind, for example, when her child cries. By doing this, the mother can become more aware of the responses her child's behavior elicits in her.

Session 5: The importance of touch. The trainer discusses the importance of physical contact for children in general, and especially for children who have experienced a disruption in caregiving. The caregiver considers how her foster child responds to her touch, and whether or not she herself has any issues with touching. Intervention is tailored to the foster mother and the child depending on their level of comfort with physical contact. Some children exhibit discomfort with being touched. In such cases, the foster parent is encouraged to hold the child on a regular basis, but to take the child's lead in breaking off the contact. Development in the child's nervous system may have gone awry or the child may have been abused in the past, causing him or her to become extremely sensitive to touch. On the other hand, the mother herself may feel some discomfort with physical contact, or she may regard it as unimportant.

It is important that the caregiver deal as openly as possible with her own discomfort. The trainer may suggest some lap games such as "this little piggy went to market" for the foster parent and child to try during the session. During the practice session, the trainer notes the child's interest in learning the finger motions, the child's excitement as the game builds to a climax, and the importance of tailoring the pace and amount of stimulation to the cues the child gives. Between this session and the next, the caregiver is encouraged to try some of the lap games with the goal of allowing the child chances to lead. The trainer emphasizes the importance of physical touch for a distressed child.

Session 6: Helping the child take charge. The main objective of the next several sessions is to help the caregiver become increasingly comfortable allowing the child to take charge. The child needs to feel he or she can have some effect on his or her own world, and the caregiver represents a key part of that interpersonal world.

In session 6, the trainer provides all the necessary ingredients for the foster parent and child to make pudding — mixing bowl, whisk, choice of two pudding flavors, milk, two small bowls, and two spoons. While the trainer videotapes the interaction, the caregiver gets the child involved in the process of choosing the flavor of pudding, making it, serving it, and eating it. The trainer and caregiver then watch the video together and discuss the caregiver's strengths in interacting with the child. They also discuss any obstacles caused by competing demands between caregiver and child, such as making the pudding, keeping the kitchen neat, or allowing the child freedom.

Session 7: Following the child's lead in play. This session builds on the last, helping the foster mother feel comfortable following the child's lead in play. The trainer discusses again the importance of allowing the child to have a sense of affecting his or her world. As the foster mother becomes more adept at responding to the child's cues, the child begins to develop a sense that the world is predictable. The caregiver's ability to follow the child's lead and to allow the child autonomy is particularly valuable in helping the child feel that he or she has some control over the world.

While being videotaped, the foster mother and child look at a book with pullouts on each page, and the child is again allowed to take an active part. The mother practices giving over some control to the child by letting the child do such things as turn pages at his or her own pace or do the pullouts. The mother again considers which aspects of the task may be difficult for her. The mother is asked to look at the book with her child several times before the next session and to allow the child to take on an increasingly active role.

Session 8: Attending to child's signals. During this session, the caregiver learns to interpret the signals her child gives for engaging during an interaction or for disengaging. The trainer encourages the caregiver to understand the

importance of staying tuned in to these signals.

A puppet introduced into the child's play illustrates for the foster parent how play and interactions that can be fun can also be frightening to children if they are intrusive or over-stimulating. The trainer helps the foster parent observe the child's response to the puppet. Reactions to the puppet could be an initial tentativeness mixed with curiosity, followed by fright or perhaps a desire to touch the puppet. The caregiver is asked to reflect on her own memories of similar feelings of excitement that can turn to fear when adults are insensitive to the child's behaviors.

Session 9: The young child's emotions. Session 9 focuses on reading the child's emotional expressions and helping the child become comfortable with his or her emotions. The trainer shows videos from previous sessions in which the child showed strong negative emotions, discussing with the foster mother the importance of allowing the child the freedom to feel the emotion. The role of the foster parent in helping the child organize those negative feelings to keep from being overwhelmed by them is also discussed.

Session 10: Bringing it all together. The trainer and caregiver review the material presented in the first nine sessions, noting progress the foster mother has made and giving special attention to areas where there is still room for improvement.

Conclusions. As the result of their early history of inadequate care and disruptions in relationships, foster infants often face challenges in forming relationships with new caregivers, and in regulating behavior and physiology. Our research efforts have helped us identify specific targets for intervention with these children. Had we not engaged in careful, systematic study of children's difficulties in functioning, but rather developed an intervention that was intuitively compelling, the resulting intervention may not be directed at the most appropriate targets. We suggest that the empirical underpinnings for intervention development are critical.

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AUTHOR NOTES

Support for this research was provided by NIMH grants R01 52135 and K02 01782 to the first author, as well as to an NIMH network grant R21 60766 with Megan Gunnar as Principal Investigator. Our appreciation to Gerri Robinson and Yvonne Gilchrist of Baltimore City Department of Social Services; and to Carlise Giddens, Laura Miles, and Kathy Goldsmith of Delaware Division of Family Services; and to case workers, foster families, birth families, and children at both agencies. Also, thanks to Emily Fenichel for helpful suggestions to improve the manuscript.

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Babies in Foster Care:

The Numbers Call for Attention

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In the United States today, almost 600,000 children are in foster care. At the Chapin Hall Center for Children at the University of Chicago, our Multistate Foster Care Data Archive (Wulczyn, Brunner, & Goerge, 2002) maintains data from 12 states – Alabama, California, Illinois, Iowa, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, and Wisconsin. The 12 states covered by our data include large states and small ones, with urban and rural counties, and ethnic variations representative of the country as a whole. If Multistate Archive trends in these states hold true for the rest of the country – as we believe they do – more than 120,000 of the children now in foster care entered placement before their first birthday. Of these, 60,000 were placed in their first month of life.

Infants and toddlers as a group are different from older children in the foster care system. They are more likely to enter foster care than are children from the 4- to 17-year-old population. Once in foster care, infants and toddlers are more likely than are older children to be abused and neglected and to stay in foster care longer than a year. These problems are particularly acute among babies who enter foster care in the first 3 months of life.

There are compelling moral, developmental, and clinical reasons for directing the attention of opinion leaders, policy makers, and the professional community to the circumstances of infants and toddlers in foster care. Data from our Archive and the National Child Abuse and Neglect Data System (U.S. Department of Health and Human Services (HHS), 2001) from 1999, provide sound epidemiological support for investing resources in this population of young children and their families. We present key findings from the studies to make the case that the time has arrived to undertake a national policy initiative on behalf of babies in foster care.

Fact #1: Babies less than 1 year old are at greatest risk of maltreatment.

- In general, the rate of substantiated reports of maltreatment (including both abuse and neglect) goes down as the age of the child goes up.
- Children under 1 are about twice as likely to be maltreated as are children between 1 and 5 years old. Substantiated reports of maltreatment are filed for 19 per 1,000 children under 1 across the country, and about 11 per 1,000 children between 1 and 5 years of age.
- The most prevalent form of maltreatment is neglect, especially among very young children. Babies are much more likely than toddlers or preschoolers to be victims of neglect — 13.5 per 1,000 for babies under 1 compared to 8 per 1,000 for children 1 to 5.

at a glance

- Infants and toddlers as a group are different from older children in the foster care system.
- Four key facts based on data from the Chapin Hall Multistate Foster Care Data Archive and DHHS document these differences.
- There is sound epidemiological support for investing resources in this population of young children and their families.

PHOTO: MARILYN NOLT

Fact #2: One in five children coming into foster care for the first time is a baby less than 1 year old.

- As of 1997, nationwide, approximately 1 out of every 100 children enters foster care during his or her first year of life.
- In 1997, approximately 25 of every 1,000 children nationwide entered foster care in the first 3 months of life – compared to 10 in 1,000 1-year-olds and 2 in 1,000 4-17-year-olds.
- Fifteen out of every 1,000 babies living in a state's most urban county enter foster care before their first birthday.
- In urban areas, 1 in 20 babies, birth to 3 months of age, enters foster care.
- In rural counties, rates of foster care placement for babies are lower, but they have been on the rise since the 1990s.

Fact #3: The very youngest children stay the longest amount of time in foster care.

- Half the babies who enter foster care before they are 3 months old spend 31 months or longer in placement.
- Children who enter foster care for the first time between 10 months and 4 years of age spend less time in care – half of the children will leave care within 18 months.
- Children who are 4 to 17 years old when they enter placement for the first time tend to spend less than a year (11.7 months) in foster care.
- The extended length of stay of children who entered foster care before their first birthday means that in some jurisdictions, 1 in 4 of all "paid placement" days is used by children who entered care before their first birthday.

Fact #4: How a child leaves placement is closely related to the child's age at placement.

- Infants and toddlers are more likely than older children to be adopted, but less likely to be reunified with their birth parents.
- Reunification rates are lowest among children who enter placement between birth and 3 months of age. Of babies who enter foster care in the first 3 months of life, 36% are reunified with their parents – compared to 56% of infants who enter foster care at 10 to 12 months of age
- Adoption rates are much higher among babies 3 months of age and younger. Thirty-eight percent of babies who enter foster care in the first 3 months of life are adopted – compared to 19% of infants who enter at 4 to 9 months of age and 15% of infants who enter foster care at 10 to 12 months of age.

What Can We Learn From These Facts?

Babies – especially the very youngest infants – are entering foster care in large numbers every year. And children who enter care in the earliest months of life stay longer in placement than all other children. This means that in the aggregate the resources that are devoted to these children represent a substantial portion of all child welfare spending.

We already spend money on babies in foster care. Can we begin to invest our resources in babies, families, and communities to better protect – and promote – the healthy development of our youngest citizens?

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Treating Infant-Parent Relationships in the Context of Maltreatment:

Repairing Ruptures of Trust

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When trust between them is ruptured, infants and parents have an immensely difficult time developing a healthy relationship. And ruptures of trust frequently are seen in foster care – between babies and parents, between parents and their own families and current partners, and often between and among children, families, professionals, and agencies. At the Institute of Infant and Early Childhood Mental Health of Tulane University Health Sciences Center, a multidisciplinary team of faculty and trainees provides assessment and psychotherapy to infants in foster care and their caregivers (see Table 1). This article describes our multilayered efforts to encourage positive change in parents, parent-child relationships, and powerful, complex systems of care.

The Team's Mandate

The Team's initial task is to conduct a thorough assessment of each child and family in order to recommend requirements for the safe reunification of these young children with their biological parents. These recommendations are given to Child Protective Services personnel and to the

This article is adapted with permission from a chapter scheduled to appear in *Interventions for Early Relationship Problems*, edited by Arnold Sameroff, to be published in 2003 by Guilford Press.

Table 1
The Institute of Infant and Early Childhood Mental Health Infant Team

The Infant Team includes faculty and trainees from the Institute of Infant and Early Childhood Mental Health. In any given year, the Team includes approximately 15 people, including child psychiatrists, clinical and developmental psychologists, clinical social workers, pediatricians, and paraprofessionals, all of whom have expertise in infant and child development. Within the Tulane University Health Sciences Center and other agencies outside of Tulane (e.g., Children's Hospital), the Team consults with and can call upon specialty care providers (geneticists, neurologists, pediatricians, and surgeons), speech-language pathologists, audiologists, and occupational and physical therapists. The Team works with public agencies including the Department of Social Services Office of Family Support, Child Protective Services, Child Net and Child Search (State grant-funded early intervention initiatives to serve children with disabilities), Bureau of General Counsel, Child Advocates Services Agency, Legal Aid Services, and Juvenile Court judges. The Team also works with child care and Early Head Start centers and staff of inpatient and outpatient substance abuse treatment programs, homeless shelters, programs for battered women, programs for perpetrators, and vocational training programs.

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Juvenile Court. Parents who have maltreated their child are ordered to comply with assessment and treatment by the Infant Team. No confidentiality exists, given the forensic decision-making inherent in the intervention program.

The Families We Serve

The families we serve are at the extremes of risk. Abuse and neglect are known to increase the likelihood of adverse mental health outcomes for children. Often, the parents are poor, unemployed or underemployed, undereducated, were abused themselves as children, have substance abuse and mental health disorders, have little emotional support, are involved in violent relationships, and/or live in violent neighborhoods. They often have had no one to whom they can turn for support or assistance.

Unique Features of Our Intervention

Given the low expectations and poor level of trust with which these parents enter treatment, our role as sensitive and empathic guides to change becomes paramount. The characterization of successful treatment in our intervention model differs markedly from the usual presumption of facilitating personal fulfillment and structural change. Minimal competence as a parent, that is, providing "safe enough" parenting such that their children can return home, is the primary goal of the intervention. Further, the treatment has well-defined constraints. The Adoption and Safe Families Act (1997) requires that a permanent plan be outlined within 12 months of the child being removed from the biological home, and that the permanent plan be implemented within 18 months of the child's removal. With these constraints in mind, the therapist may feel some pressure to move more quickly, be more active, and confront more frequently than he/she might in a more traditional therapeutic setting. Successful intervention is defined by reunification of the birth parent with the child or freeing the child for adoption if reunification is not possible. If time permits, and the parents are able and willing, treatment may proceed to address more fully the myriad difficulties with which these families present. Reaching loftier and more ambitious goals then may become possible.

Infant-Caregiver Relationships

The infant-caregiver relationship provides the primary context for therapeutic intervention, and as such presents a special challenge. In choosing a psychotherapeutic model for the dyads we treat, matching the paradigm to the needs of the infant and parent is essential. Further, these needs may change over the course of the intervention, requiring use of different therapeutic modalities or approaches over time. To complicate matters further, the infant in foster care has several significant relationships, each of which must be addressed simultaneously by our Team. The biological parent and infant typically receive intensive therapeutic attention. The foster parent and infant relationship also is a focal point, particular-

PHOTO: ZERO TO THREE

at a glance

- We make multilayered efforts to encourage positive change in parents, parent-child relationships, and complex systems of care.
- The primary goal of intervention is helping parents provide "safe enough" parenting through individual psychotherapy, dyadic psychotherapies, and ancillary treatments.
- In dyadic psychotherapy, we use models based on the work of Alicia Lieberman and her colleagues and Susan McDonough's Interaction Guidance.
- Our intervention reduced a child's risk of subsequent maltreatment by 68%.

ly to facilitate the security, stability, and responsiveness of the placement. The final dyad that presents for treatment frequently contains an element of the unknown, namely, the potential adoptive parent. Even if this "parent" is the current foster parent, the nature and dynamics surrounding the adoption process elicit a variety of issues that are different when one is fostering versus adopting. To add to the complexity, more than one biological caregiver, foster parent, or adoptive parent usually are identified, all of whom must be assessed and perhaps treated with the infant. Thus, treatment plans for each infant and caregiver must be individually tailored to achieve maximum likelihood of serving the child's best interests. In addition, a major goal of our intervention is to change the systems in which the infant-caregiver relationships develop and are maintained. Accomplishing these goals in a timeframe sensitive to the needs of the child requires clarity of purpose and flexibility on the part of the therapist.

Interventions

Our therapeutic approaches are complex and multilayered. Typically, biological parents are engaged in individual, dyadic, and ancillary treatments. Most caregivers are engaged in psychotherapy involving the infant, typically from the initiation of their treatment. Often, biological parents' own experiences in childhood have been as difficult as or worse than their child's experiences. Many parents report serious maltreatment, and typically are unaware of the connection between their own experiences as children and their current emotional and behavioral responses as parents. Intervention occurs for several – usually at least 6 to 12 — months. Sometimes, families continue to work with a clinician for 18 months.

To begin dyadic work with the infants and parents, we require that the parents first establish a commitment to treatment, as evidenced by attending individual psychotherapy sessions consistently. We assess whether they have an investment in remediating the circumstances in which they find themselves. We require that parents demonstrate dedication to the therapy, and once they are reasonably engaged, we introduce dyadic treatment.

Dyadic Psychotherapies

Therapeutic Visitation

We use a variety of techniques in the treatment of infant-parent dyads. For cases in which visits between the biological parent and the infant are tumultuous or detrimental to the child, we use therapeutic visitation as a precursor to infant-parent psychotherapy. In some instances, visits between the parent and child are compromised due to the parent's physical or emotional absence in the child's life, so that the infant does not know the parent and is frightened by being left with this "stranger." At times, the parent is angry and unable to contain feelings of rage in the child's presence, which clearly can be traumatic for the infant. In initiating therapeutic visitation at our clinic, we hold preparatory sessions with the biological parent alone to enlist cooperation in recognizing the child's perspective in having contact with the parent. Individual sessions with the parent continue until we believe he/she can behave in a nonharmful way with the child. Then, visits occur in our clinic, where we bring the child into the session and offer support to the dyad. We assist the parent in providing structure and consistency to the visits. We also praise positive interactions and give gentle instruction when necessary. Eventually, the visitation evolves to more formal infant-parent psychotherapy.

Infant-Parent Psychotherapy

We use two models of dyadic psychotherapy, one based on the work of Alicia Lieberman and her colleagues (Lieberman et al., 2000) and the other based on the work of Susan McDonough (McDonough, 2000). In Lieberman's model, the parent and infant are seen together and the focus is on links between the parent's experience of her infant and her own relationship experiences, current and past. The parent's subjective experiences of herself as a mother and of herself as a child are explored. Observed interactions with the infant in the sessions are used by the clinician to discuss the mother's affective responses. A positive, trusting therapeutic relationship helps the mother to experience herself as a loving and worthy person and caregiver. We challenge negative attributions about herself and her child through sensitive support and interpretation. We believe that the mother's behaviors change as her perceptions and representations of her infant, herself, their relationship, and her prior experiences change. These representational changes are necessary for her to show meaningful modifications in her parenting behaviors.

We use the Lieberman model of infant-parent psychotherapy with several types of dyads. We have found it to be very effective when the parent has the capacity for insight, curiosity about the self, and/or a pressing internal conflict about the circumstances in which she finds herself. Lieberman's model provides a fertile mechanism for exploration when parents display intense interpersonal affect, usually towards the child. We also use this method of intervention when parents have access to memories for past (usually traumatic) events, but no affect associated with the memories. Therapeutic explorations may lead to new discoveries about the self as a parent and as a responsible adult, as well as discoveries about the infant. Changes in these perceptions provide the basis for constructive adaptations leading to improved interactions between the parent and baby. We videotape the sessions for later viewing and processing by the parent and clinician.

The case of Natalie and George illustrates the implementation of infant-parent psychotherapy with a mother who recounted, in a matter-of-fact way, her childhood experiences of horrendous physical and sexual abuse by trusted family members. Her young son was active, and at times, oppositional, but always filled with a zest for life and for discovering what life has to offer.

Natalie and George

Natalie, age 30, and her 3-year-old son, George, were referred to our project because she failed to protect him from the partner violence in which she and his father were engaged. George was taken into custody and placed in a foster home. Following an extensive evaluation, we began infant-parent psychotherapy concurrently with individual psychotherapy for Natalie. Natalie presented with curiosity about the circumstances in which she found herself, but with little affect attached to memories of her past and current abuse. George presented as an active, bright boy who was inquisitive and responded well to the structure and routine maintained by his foster parents. In treatment, Natalie, who had problems setting limits with him, easily overstimulated him. A frequent question she asked in the initial weeks of treatment was "Why can't he be good, since he knows better?"

It was only when Natalie recognized and developed empathy for the little girl inside herself who had been ridiculed and abused, that she began to understand her behavior with George and her unrealistic expectations for him. As a child, she had been forced into a caretaking role early on, providing physical and emotional support for her siblings and her mother. When she was repeatedly sexually abused by her uncle, her mother had failed to protect her. No time had been devoted to her own emotional needs or desires, and the only playful interactions she recalled were her affectionate boxing matches with her grandfather, who had been a professional boxer.

In infant-parent psychotherapy, Natalie made connections between her own missed childhood, her anger at adults in her past, her need to be playful, and her son's desire to play as well. She wanted to provide opportunities for George to be a child, but the only play she knew was boxing. During a dyadic session, she held a boxing match with her 3-year-old, who punched her forcefully in the arm. Natalie became quite angry with him, and scolded him harshly. It took some time for her to understand that in this scene, she was re-enacting both her rage at her mother for disappointing her and her mother's impatience and insensitivity to her experience. Gradually, she came to appreciate her difficulty in protecting George and in helping him understand and express his impulses and feelings. She also came to understand that, while boxing was the healthiest form of affection she had experienced as a child, she and George needed to learn other ways to demonstrate their love for one another. After more than a year of treatment, they had dealt with their issues of anger and loss, they learned healthy ways to express caring and nurturance, and Natalie consistently set appropriate limits for George. The two were then reunited.

Interaction Guidance

For cases in which the parent is young, cognitively limited, or emotionally unavailable due to chronic trauma, we often use McDonough's psychotherapeutic approach (McDonough, 2000). Interaction Guidance is a strength-based model specifically devised for families with multiple risk factors, including poverty, substance abuse, mental illness, lack of social support, and minimal education. The parent is supported in understanding the child's development and behaviors through interactive play experiences. The clinician guides but does not undermine the parent's role as a competent caregiver. Enjoyment in the dyad's interactions is highlighted, and insensitive interactions are shaped such that they become nurturing. In Interaction Guidance, small samples of the videotaped session are viewed during the latter half of the therapy hour. This methodology allows for immediate feedback to the parent about her behaviors with the infant, as well as her affect during play with the baby. The clinician points out positive and satisfying interactions, and elicits comments from the parent regarding her own experience of the baby. Eventually, these strengths are used to help modify negative behaviors the parents display with their infants. The parents may at times reflect upon their own difficult experiences, either currently or in their childhood. These reflections are discussed in the context of providing relevant material for strengthening the relationship between the parent and infant. In Interaction Guidance, we believe that our focus on overt behaviors between the mother and infant indirectly impact caregiver and infant representations.

The story of Mona and Andy illustrates the case of a young mother who had traumatic experiences for which she had virtually no memory, except to recall being placed in numerous foster homes due to maltreatment on the part of her mother. Andy was a quiet, affectionate toddler with his foster parents, but he expressed little affect with Mona.

Mona and Andy

Mona, age 23, and her 2-year-old son, Andy, were referred to our project because she had left him and his siblings alone in the home for several hours. Mona suffered from long-standing depression, and she presented to our clinic with emotional blunting and virtually no recall of her childhood. She knew she had been removed from her mother's care at 5 years of age and that she lived in an untold number of foster placements until she reached age 18. Andy presented as an adorable but reticent toddler who posed no problems for his foster parents.

Mona began with individual psychotherapy. She discussed the conditions that brought her to the attention of Child Protection and the unhappy relationship she had with Andy's father. She was unable to speak in any detail about current or past events, and showed

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no discernable emotions in therapy. There were periods in which there was silence for minutes at a time. Efforts to engage her were unsuccessful. After a few weeks, we began dyadic work with Andy using Interaction Guidance. Her response to the therapist's observations of her gazing at Andy, and his seeking out her attention, resulted in her rolling the ball to him in our clinic playroom. His obvious delight and laughter elicited smiles from her. She quickly generalized these positive interactions in her sessions with her son. However, her interactions with Andy also included passivity in response to his autonomous play and teasing in response to some of his bids to engage her in cooperative exchanges.

In individual work, Mona was able to discuss her daily activities in general ways. She was unable to discuss in any detail, past events, her future plans, or any feelings associated with the past, present, or future. The therapist pointed out the contrast between her warm interactions with Andy and her typical withdrawal and silence in her individual sessions. Nevertheless, we understood that in her quiet way, Mona was using the therapist's presence as a secure base for her play with Andy and for reflection about herself. Both in individual and dyadic work, she never missed a session and never wished to end a session prematurely. She frequently called to be sure the therapist would be there when she came. In individual treatment, she and the therapist sat quietly together for weeks. One day, in individual therapy, after asking her what her current silent state reminded her of, she replied "When I laid behind the washing machine in the laundromat where my father raped me." She went on to talk about being repeatedly molested by her father since the age of 14, never having disclosed this to anyone. With this revelation, she began to address her incredible pain, her devastating losses, and her inability to hear her children's cries in the face of her own despair. She made progress in individual treatment, and her teasing and passive behaviors with Andy in Interaction Guidance were replaced by lively, creative playful exchanges between them. After 18 months of work, they were reunified.

Process of Change

These cases illustrate that both these models of dyadic psychotherapy can facilitate changes that result in a viable infant-parent relationship. There are several possible transformations in a caregiver's representation that we look for to indicate progress in her ability to provide safe parenting to her children. The parent must be able to see the child as a unique individual, not as rejected parts of the self or powerful (often malevolent) figures from the parent's past. The parent also must develop an empathic appreciation of the child's experience, as well as a commitment to place the child's needs ahead of her own. She must accept responsibility for the child's maltreatment and entrance into foster care. She must be able to recognize her failure to protect the child and see herself as an effective protector. She must change her behavior as a parent to ensure the safety and protection of the

PHOTO: MARILYN NOLT

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infant. Understanding that help and change are possible is a basic tenet the parent must recognize, often a difficult feat for parents who themselves have had chaotic lives and been the victims of maltreatment as children.

Changes in representations often change behaviors. Conversely, the route to representational changes may be behavioral. When an infant's "difficult" behaviors or symptoms are reduced, the parent may see the child as a more pleasurable companion, and perceive their relationship in a more positive light. This view may bring about more satisfying interactions in the dyad, which in turn enhance the parent's positive attributions about the baby. Nevertheless, we believe it is the changes in the representation upon which enduring behavioral change is predicated.

With this framework in mind, we believe that it is crucial for parents to develop trust in the social services system, of which we are representatives. Most have no faith that others are trustworthy or supportive, and they enter our system with the added pressure of scrutiny from Child Protection personnel and the Juvenile Court. Therefore, establishing trust with parents is both challenging and critical for effective treatment.

We facilitate building trust by meeting with parents regularly, in a timely fashion, and listening in a nonjudgmental way to the stories of their lives. We do so in part to communicate to them that they are worthy of help and capable of change. They must trust us as a guide to change, and experience us as helpful. In part to establish the parent's trust, we also engage in case management, offer concrete assistance, and provide crisis intervention, as needed. We believe that by being ready to face challenges with the parents in a supportive manner, we communicate that we care about them regardless of the abusive behavior in which they have engaged with their child. This ability to accept and forgive provides a healthy model they can apply to themselves. They may be able to forgive those who violated their trust and who maltreated them. These positive changes can be translated in their relationships with their babies. To enhance behavior changes, we may use behavior management techniques, developmental guidance, or skills training in addition to infant-parent psychotherapy. In the majority of cases, infant-parent therapy with foster parents is in the form of interaction guidance or behavior modification.

We believe that by being ready to face challenges with the parents in a supportive manner, we communicate that we care about them regardless of the abusive behavior in which they have engaged with their child.

Individual Psychotherapy With Parents

Many parents present with numerous individual difficulties that impede their ability to parent their children safely and effectively. These include psychiatric illness, particularly affective and post-traumatic stress disorders, substance use and abuse, and conflicted relationship styles. Thus, we conduct individual psychotherapy without the infant present frequently, even when the parent and child also are participating in dyadic work. Nevertheless, all therapy in which the parent is engaged is introduced and conducted with the parents' current and future caregiving strategies in mind.

Psychotherapy With Infants and Young Children

It is rarely the case that a maltreated infant has no symptomatology, so we address symptoms and problematic behavior using the most appropriate format, given the nature of the symptoms. Many times, infant-parent psychotherapy resolves symptoms, such as relationship disturbances or flat affect in the infant. But at other times, or in addition to dyadic work, the young child would benefit from individual therapy, a behavior modification plan implemented with foster parents and day care providers, or medication management. Individual therapy is helpful in enhancing the child's representation of the self, which frequently is damaged by the maltreatment and removal from the home. We most commonly address the following issues in therapy: recognition of emotions, labeling affect, affect regulation, building trust, understanding and establishing appropriate boundaries, increasing social skills, decreasing aggressive and other disruptive behaviors, and decreasing sexualized behaviors. At times, we conduct peer interaction groups, especially for extremely aggressive toddlers, attempting to promote emotion regulation and prosocial skills.

Ancillary Treatments

Adjunct therapies sometimes are necessary to remove barriers to effective functioning such that parents can begin to address issues in individual and dyadic treatment. We make referrals for these types of services to programs inside our facility or to outside agencies. For example, substance abuse counseling, special education services, and vocational counseling for parents are referred to others. Most of the children with whom we work have both receptive and expressive language delays, and we refer them for speech and language evaluation and therapy as needed. Other services for which we refer include genetic and neurological evaluation, and occupational and physical therapies. The Team retains responsibility for coordinating and integrating treatment efforts.

Systems Intervention

Our work is embedded within a larger social context; our families are asked to deal with myriad powerful and complex systems of care. A major goal of our Team is to

educate those in these systems about the unique and special needs of infants and very young children in foster care. We address developmental trajectories of young children, the importance of stability and consistency in caregiving, the necessity of having a primary caregiving relationship, and the need for considering the child's best interests in a timeframe that is sensitive to the infant's optimal development. For example, we have educated juvenile court judges about the detrimental effects of continuations of review hearings, potentially extending the time period in which the child's permanent placement remains undetermined, and perhaps impacting the child's attachment relationship to the "permanent" caregiver. Similarly, we have educated Child Protective Service case managers about the negative impact of abruptly removing a child from a placement with no preparation; this denies the child the opportunity to have closure with and say good-bye to the foster family, thus inadvertently exposing the child to yet another unanticipated removal from the "home."

In addition to working with juvenile court judges and CPS case managers, we try to improve integration and coherence of a range of services so that families can better comply with their case plans.

We also attempt to help families at high risk to navigate through these complex systems. We try to enhance families' access to services, recognizing that differing bureaucratic and administrative requirements for obtaining services are so complex and cumbersome that our families do not avail themselves of the benefits to which they are entitled. Therefore, improving integration and coherence of services enables families to better comply with their case plans. For example, we have helped young mothers receive child care assistance, which allows them to pursue educational or career goals. We also have identified that virtually all of the children in our program have receptive and/or expressive speech delays. Our early identification allows for early intervention, hopefully preventing in our children the possible development of learning problems and associated difficulties with mastery and self-esteem.

Outcomes

Our work is making a positive difference for vulnerable children and families – reducing the risk of maltreatment and placement into foster care. To assess the efficacy of our treatment, we compared the outcomes of children involved in our intervention program (Intervention Group) to outcomes for a group of children whose maltreatment had been substantiated in the 4 years before our program began (Control Group). We asked two questions:

1. Will a child who has been maltreated be maltreated again?
2. Will a mother who has maltreated one child maltreat another child?

We knew the answers to these questions for the children and mothers in the Control Group before the Infant Team began providing services. Thus, we could calculate an "expected occurrence of recidivism" for our Intervention Group. In other words, we could estimate that among a given number of children who had been maltreated and mothers who had maltreated children, a certain number of children could be expected to be maltreated again and a certain number of mothers could be expected to maltreat another child – if no intervention were provided. Then we measured the "observed occurrence" of subsequent maltreatment among the children and parents in our Intervention Group. How did subsequent maltreatment of children and by mothers in the Intervention Group (observed occurrence) compare with what we would have expected them to experience without treatment (expected occurrence of recidivism)? We found that our intervention reduced a child's risk of being maltreated by 68%; it reduced a mother's risk of maltreating a subsequent child by 75% (Zeanah et al., 2001). Our approach is one of prevention. We believe it has the potential to impact a family's development long after the child is no longer in care.

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SHARING CHILD DEVELOPMENT EXPERTISE IN COURT:

Respect, Rules, and Roles

PHOTO: COURTESY MARICE COHN BAND

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Critical decisions about the health, safety, and well-being of young children are made every day in United States courts. Judges who make these decisions and attorneys who represent children and families are increasingly calling upon child development professionals from many disciplines to inform them about factors that affect children's well-being. Child development professionals often use written materials, presentations, and informal seminars to increase judges' and attorneys' general knowledge about very young children's development, needs, and the resources available to them and their families. When a court must make decisions about a specific child, judges and attorneys may call upon child development professionals to share their expertise as evaluators or expert witnesses in court.

Expert testimony can make a tremendous difference in the way courts approach decisions affecting very young children. The knowledge that child development professionals bring to the discussion of one child's circumstances not only informs the court's thinking about that child but also builds the court's capacity to address the needs of other young children more knowledgeably. From our experience as judges (Grace and Lederman) and as a frequent witness in court and collaborator with judges on behalf of very young children (Osofsky), we offer some guidelines to help child development professionals effectively share their invaluable knowledge in court.

Using your expertise effectively in the courtroom involves **respect** – for the court, for the child and family, for

your profession, and for yourself. It also involves understanding **rules** (the laws, traditions, and procedures that govern the judicial process) and **roles** (the expectations of judges, lawyers, and witnesses).

Respect

The issues that come before a court are serious; the decisions made by the court are often life changing. Although everyone involved may be making a genuine effort to consider a young child's current and future well-being, often there is no good solution available for the child or family – the court may be able to try, at best, to minimize or balance further harm to children and adults who have already been badly hurt. In the context of a courtroom, applying the principle from clinical practice that "how you is as important as what you do" means demonstrating respect for all the participants in the judicial process and for the process itself.

Show your respect for the judicial process by thorough preparation.

- Know the exact issues that the court must decide (for example, custody, placement, termination of parental rights, terms of visitation, or medical authorization).
- Thoroughly review your own file about the child and family. Bring the file with you to court if possible, with critical passages marked for easy reference in case you are asked a question to which you do not remember the answer.
- Keep testimony (written or oral) clear and concise. Explain any professional language in lay terms, but be careful not to appear patronizing in your definitions. In written testimony, include a summary and conclusions.
- Prepare to be questioned. Be ready to support generalizations and principles with evidence and examples.

Show your respect for the child and family through candor and self-awareness.

- Let the court know how much time you have spent with a child and family. Have you worked with them for years or have you spent only a few hours with them?
- If you are appearing as an advocate for an individual, talk about your relationship with the parties before the court and let the court know why your testimony is biased in favor of that person's position.

Show your respect for your profession by knowing and adhering to your profession's guidelines for testifying in court.

- Do not overstep your expertise. "That is not in my area of expertise" is an appropriate response to many questions.
- If asked, you may point out that not all experts in your field have the same approach or agree with each other.

Show respect for yourself by appreciating that you are the expert about what is needed for a young child's well-being, and that the court values your professional insights.

- Voice your opinion unequivocally if requested to do so. Issues before a court are always complex. You may admit a lack of certainty or qualify an answer by saying, "Based on my knowledge of child development and the circumstances of the case, I would anticipate…." You may also recommend that the court reexamine its decision at a future date.
- If you wish to add to your testimony after having been cut off, your attorney may ask you, when he/she has the opportunity to re-direct the questioning. (It is essential for you to meet with the attorney in advance to work out what strategies you could use if you want to get additional information in your testimony.) If you have been cut off by an objection that has been sustained by the judge, you must wait for a question to be addressed to you to clarify your position (see "Rules" below).

Rules

The judicial process is shaped by historically evolved rules of evidence, as well as by specific legislation (for example, the Adoption and Safe Families Act) that frames the issues that are relevant to the court's inquiry. You can testify well without knowing the rules thoroughly.

- **You can generally speak only in response to questions.** Work with the attorney who has asked you to testify (see "Roles" below) so that his or her questions give you an opportunity to articulate your expertise and concerns to the court.
- **The rules of evidence constrain the types of questions that judges may ask, but judges' philosophy, knowledge, and style also influence their questions.** As judges become more knowledgeable about early childhood development, they are likely to demand more precise and pertinent information on which to base their decisions – for example, a thorough developmental assessment, or answers to the list of ques-

at a glance

- Expert testimony can make a tremendous difference in the way courts approach decisions affecting very young children.
- Often there is no good solution available for the child or family; the court is trying to minimize harm to children and adults who have already been badly hurt.
- Using child development expertise effectively in the courtroom involves demonstrating respect for all involved in the process, and understanding rules of the judicial process and the expectations of judges, lawyers, and witnesses.

tions on children's health and development created by the New York State Judicial Commission (see Dicker et al., this issue).

- **Rules of evidence often allow attorneys to object to another attorney's or the judge's questions.** If an attorney objects to a question or to what you are saying, stop speaking and wait for the judge to rule.
- **You may ask for clarification of questions.** Some questions ask for elaboration; others require a "yes" or "no" answer. If you think a "yes" or "no" answer is inadequate, you may say, "I cannot answer that question with a 'yes' or 'no' answer."
- You should also be aware that a judge's rigorous adherence to rules of evidence is required by law and failure to do so could result in a case being overturned on appeal. Because the appellate process is often so lengthy, judges seek to avoid an appeal, which lengthens the time it takes to find a permanent solution for the child.

The general expectations of judges, attorneys, and witnesses in the courtroom are well-defined by law and precedent, but they are not intuitive – they must be learned.

Roles

The general expectations of judges, attorneys, and witnesses in the courtroom are well-defined by law and precedent, but they are not intuitive – they must be learned.

- **The judge is responsible for decision making in the court.** Like other professionals, judges bring a lifetime of training, professional experience, and personal experience, beliefs, and values to their role. In making decisions involving young children, some judges will place more emphasis on consideration of parental rights, while others will focus more attention on likely implications of a given decision for the individual child's current and future development. Most judges know only as much as the general public about child development and children's mental health; this is why they ask child development professionals to educate the court with their testimony. Because judges rule on the basis of the evidence presented to them, attorneys and witnesses must work together to insure that the court receives complete testimony.
- **The attorney's role is to represent his or her client's interests as effectively as possible.** Part of the job of the attorney who has subpoenaed you to testify is to develop a set of questions to ask you so that, within the rules of evidence, you will be able to get appropriate information into the court record. This attorney should also help you anticipate the questions you will be asked by opposing counsel, and give you information about the judge that will help you frame your testimony meaningfully. Cross-examination of witnesses is part of an attorney's role; understand that questions asked in cross-examination are not a personal attack.
- **As a witness, your role is to enhance the judge's ability to make an informed decision.** If you are asked for facts, try to report them without interpreting them. Do not overstep your expertise. Present your testimony as impartially as possible, being aware of your own beliefs and values and acknowledging the source of any bias (for example, your relationship with one of the parties). The question-and-answer format, expectations of definitive statements, and frequently adversarial atmosphere of the courtroom are likely to be unfamiliar to child development and mental health professionals who are trained to encourage dialogue, tolerate ambiguity, and find common ground among people with different perspectives. If you have little court experience, role-playing can be very useful preparation for presenting testimony and handling cross-examination.

In Closing

Judges want to make intelligent, informed decisions. They want to help the children and families who appear before them. But they must rely on the evidence and testimony presented to them case-by-case in court as the bases for the life-changing decisions that are their job to make each day. By learning the rules of the judicial process, appreciating the importance of your role within it, and demonstrating respect for all participants and for the process yourself, you will contribute to a more informed decision on the day you testify and enhance the court's capacity to serve young children and families knowledgeably and well.

BUILDING A PATHWAY TO WELL-BEING:

The Story of the "Healthy Development Checklist for Children in Foster Care"

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PHOTO: ROBERT LIEBERMAN

In November 1999, the New York State Permanent Judicial Commission on Justice for Children (The Commission; n.d.) introduced the "Checklist for Healthy Development of Foster Children" (see Table 1) as the centerpiece of its strategy to focus all those involved in child welfare proceedings on the well-being of children in foster care. Judges, advocates, and child welfare professionals throughout New York State and nationwide are using the Checklist at the earliest possible point to elicit information about a child's health and developmental and emotional needs and to identify services to address these needs. As a result, many children have received the basic health care they are entitled under federal and state laws. The Commission envisioned the Checklist as a tool not only to enhance a child 's healthy development, but also to shape permanency planning. This article tells the story of the Checklist — its creation, implementation, and successes, and the next steps required to link the healthy development of children in foster care and permanency decision making.

Developing the Checklist

The Commission (the nation's only children's commission based in the judiciary), chaired by New York State Chief Judge Judith Kaye, developed the Checklist as part of its mission to improve outcomes for children whose lives and life chances are shaped by the court system. Since 1991, the Commission has focused on the problems of young children

This article was enhanced by the experience and knowledge of Steven Blatt, M.D., Trista Borra, M.S.W., Susan Chinitz, Psy.D, Judge Joan Cooney, Jane Corriano, R.N., Susan Davis, Ph.D., Judge Cindy Lederman, Judge Nicolette Pach, Michele Schauer, J.D., and Judith Silver, Ph.D.

at a glance

- The "Checklist for Healthy Development of Foster Children" is the centerpiece of the New York State Permanent Judicial Commission on Justice for Children's strategy to focus attention on the well-being of children in foster care.
- This article describes the steps involved in developing the Checklist, implementation, and examples of successful use, as well as challenges ahead.
- Health care and child development professionals can play a critical role in helping to bridge the gap between clinical settings and the court.

and the courts. Its earliest research found that young children in foster care were not receiving needed medical, developmental, or mental health services.

The Commission first addressed the lack of services to young children in foster care by playing a pivotal role in securing implementation of Part H (now Part C) of the Individuals with Disabilities Education Act (IDEA) in New York State by the passage of the New York Early Intervention Laws of 1992 and 1993 and their regulations. The Commission's focus on the well-being of children in foster care was further amplified by its designation by New York's highest court, the New York Court of Appeals, to implement the New York State Court Improvement Project (CIP), a federally funded project to assess and improve foster care, termination of parental rights, and adoption proceedings. Under the CIP, the Commission conducted research that found few court orders for services for children in foster care, little indication in court records or proceedings that services were being provided to these children, and only rare inquiries about the health status of children in foster care or their need for services. The Commission's monitoring of the New York Early Intervention Law also revealed that young children in foster care were not being connected to early intervention services. Our early intervention and CIP efforts began to flow together as we learned of research nationwide that documented the fragile health and disabilities among children in foster care and the lack of services to address their needs.

The Commission initiated activities to alert policymakers about this research. Tl ese efforts included Commission staff speaking at state and national conferences, seeking reform in the early intervention system, and securing a focus for the first time on children in foster care in the 1998 Early Head Start Request For Proposals issued by the Head Start Bureau, U. S. Department of Health and Human Services. But, these efforts were not enough to ensure the healthy development of children in foster care. It became clear that a more focused initiative was required to spotlight the grim health prospects of children in foster care and its impact on their prospects for permanency. Thus, the Commission developed the Healthy Development for Children in Foster Care Initiative. The initiative recognizes that every court proceeding presents an opportunity to inquire about a child's needs and the caregivers' capacity to meet those needs. It also reflects the Commission's belief that judicial leadership can focus the attention of all those involved in a child protection case on a child's health as an essential component of case review and permanency planning.

To develop a strategy to address the needs of children in foster care and improve delivery of health services for these children, the Commission convened a Health Care Working Group. Its members included judges, lawyers, pediatricians, child advocates, and state and local officials. In addition to the prevalence of health problems identified among children in foster care, two trends in New York State signaled an urgent need for the Working Group. First, draft reports by the New York State Departments of Social Services and Health documented that the health care delivery system for New York's children in foster care was inconsistent across the state with inadequate access, coordination, monitoring, and oversight of services (New York State Department of Health, 2001). Indeed, one-third of children had not received the required comprehensive exam and a large percentage of children had unmet health care needs, particularly lack of mental health services and little follow-up care by specialists.

Table 1
The Commission's "Checklist for the Healthy Development of Foster Children"

1. Has the child received a comprehensive health assessment since entering foster care?
2. Are the child's immunizations up-to-date and complete for his or her age?
3. Has the child received hearing and vision screenings?
4. Has the child received screening for lead exposure?
5. Has the child received regular dental services?
6. Has the child received screening for communicable diseases?
7. Has the child received a developmental screening by a provider with experience in child development?
8. Has the child received mental health screening?
9. Is the child enrolled in an early childhood program?
10. Has the adolescent child received information about healthy development?

Source: New York State Permanent Judicial Commission on Justice for Children, n.d., p. 6.

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Table 2
Health Status of Children in Foster Care

- Nearly 80% are exposed prenatally to maternal substance abuse.
- Forty percent are born at low birth weight or prematurely.
- Eighty percent have at least one chronic health condition and 25% have three or more chronic problems — three to seven times the rate found among other children living in poverty.
- One-third to one-half have dental decay.
- More than half have developmental delays including motor development problems, hearing and vision problems, growth retardation and speech-language delays — four to five times the rate found among all other children.
- Ten to 25% have growth retardation — twice the rate expected to be found among the general pediatric population.

Sources: Blatt & Simms, 1997; Chernoff, Combs-Orme, Risley-Curtiss, & Heisler, 1994; Halfon, Mendonca, & Berkowitz, 1995; Hochstadt, Jaudes, Zimo, & Schachter, 1987; Silver, Amster, & Haecker, 1999; Swire & Kavaler, 1977; Takayama, Wolfe, & Coulter, 1998.

Second, the Commission recognized an opportunity to address the health needs of children in foster care in New York State's movement toward statewide Medicaid managed care. The initial Working Group meetings explored existing standards of health care and health care delivery models to children in foster care throughout New York State and the country.

Judge Kaye urged the Working Group to develop a strategy where the court could exercise leadership to ensure the healthy development of children in foster care. Her guidance focused the Working Group's efforts on developing court-based innovations, the hallmark of the Commission's prior successes.* It also saved countless hours of fruitless policy wrangling since New York State was not inclined to include most children in foster care in managed care plans or to develop new standards or systems for health care for children in foster care. In response to Judge Kaye's charge, we explored how to use the authority of the courts and the experience of the New York State CIP to enhance the healthy development of these children. We also used our knowledge of the overburdened court and child welfare systems to develop a simple tool that would spotlight the most basic health needs of children involved in child protection cases. We wanted to develop a tool that could be used by all those involved in the court process and believed that one person — judge, attorney, Court Appointed Special Advocate (CASA), or caseworker — asking questions about a child's healthy development could enhance a child's well-being. Our research revealed that no guide on the basic health needs for children in foster care aimed at court and child welfare professionals existed — the Checklist would represent a new resource. A pediatrician on our Working Group suggested a Checklist of basic questions that parents might ask for their own children. Judge Kaye endorsed this concept and the Checklist was born.

The Working Group and Commission staff worked closely with the New York State chapter of the American Academy of Pediatrics to choose the Checklist questions and to write the booklet, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals* (The Commission, n.d.). The booklet is a companion tool to the Checklist, providing reasons for asking each question and references to expert sources. In developing the Checklist and booklet, Commission staff consulted with pediatricians and child development specialists to identify the most critical guideposts for children's health. The Checklist also incorporates the more stringent standards of health care for children in foster care as recommended by the American Academy of Pediatrics and the Child Welfare League of America. Judge Kaye viewed the Checklist and booklet as so critical to the court process that she reviewed each draft.

The Checklist questions reflect the Commission's core mission to assist the court in improving outcomes for children. To ensure the legitimacy of the Checklist and encourage its use by judges and attorneys, the questions are consistent with the legal standards for health care as outlined in the federal Medicaid law through the Early and Periodic Screening, Diagnosis and Treatment

Table 3
Health Services for Children in Foster Care

A study by the U.S. General Accounting Office of children under age 3 in three urban areas serving half of all young children in foster care found:

- 12% received no routine health care;
- 34% received no immunizations;
- 32% continued to have at least one unmet need after placement;
- 78% were at high risk for HIV, but only 9% had been tested; and
- less than 10% received services for developmental delays

Source: U.S. General Accounting Office, 1995.

* The Commission established the nation's first statewide system of children's centers in the courts and developed model court projects (two are also Model Courts of the National Council of Juvenile and Family Court Judges) under the New York State Court Improvement Project.

(EPSDT) provisions, as well as the requirements for health care to children in foster care under New York law. We were careful to ensure that the Checklist contained primarily those screenings and services that children in foster care are entitled to receive under the law. The Checklist also is premised on the court's authority under State law and federal law — the Adoption Assistance and Child Welfare Act of 1980 and the Adoption and Safe Families Act — to make inquiries about the health of children in foster care and write court orders for services to address their needs. We based the Checklist on the law to assure judges, attorneys, and child welfare workers about their authority and obligation to ask the questions. In essence, we sought for the Checklist to be viewed as augmenting existing responsibilities and not adding additional burdens.

Implementing the Checklist

Judge Kaye unveiled the booklet during her keynote address at the November 1999, Millennium Conference sponsored by the U.S. Department of Health and Human Services, Children's Bureau, the National Council of Juvenile and Family Court Judges, and the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. She stated that the goal of the booklet is

> to expand awareness of the importance of these health issues for children's life prospects. Addressing these needs will both enhance their physical health and decrease the probability of placement disruption. That means it will increase the likelihood that these children will grow up in stable, loving, permanent homes.

The booklet and Checklist were distributed to all participants at the conference including all of the 49 state court improvement projects, 22 model courts of the National Council on Juvenile and Family Court Judges, and federal child welfare officials. In New York State, the Commission shared the Checklist with all family court judges, local social services and health commissioners, early intervention officials, public health nurse directors, law guardians or children's representatives, parents' attorneys, agency attorneys and caseworkers, court appointed special advocates (CASAs), and service providers. To date, the Commission has disseminated over 20,000 booklets nationwide.

As those involved in child welfare proceedings began to use the Checklist, several challenges emerged. First, court and child welfare professionals required training on child development, available community resources, and how to use information about a child's health needs in making decisions not only about services, but also concerning placement, visitation, and permanency. To meet this need, the Commission embarked on an intensive training effort and developed an impressive roster of trainers comprised of judges, attorneys, pediatricians, and child development specialists.

Our training curriculum provides an overview of the medical, developmental, and emotional issues prevalent among children in foster care, describes their legal entitlement to health and developmental services, and identifies resources that can ameliorate the problems and enhance caregivers' ability to meet their child's needs. For most judges and attorneys, this training is their first exposure to child development research as well as entitlements and programs such as EPSDT, early intervention, and Head Start. Every training session highlights the link between healthy development and permanency and offers strategies to build collaborative partnerships between those involved in the court and child welfare systems and professionals working in the fields of health, child development, and early childhood education. In addition, the Commission staff has published several companion materials to the Checklist and made presentations at meetings sponsored by national organizations including ZERO TO THREE, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, the American Bar Association, the National Council of Juvenile and Family Court Judges, and the National Association of Court Appointed Special Advocates (Dicker, 1999; Dicker & Gordon, 2000a, 2000b, 2000c).

Second, implementing the Checklist required resources to assist the court in asking the questions, gathering information, and translating the results of screenings and evaluations relevant to permanency decision making. The Commission identified existing resources to meet this need — CASAs and legal and nonlegal resources. The Commission developed its CASA Project to harness the resources and expertise of CASA volunteers to use the Checklist on cases assigned to them by a Judge. CASAs are specially trained community volunteers appointed by a family court judge to assist in finding safe and permanent homes for children in the child welfare system. Once appointed, the CASA becomes an official part of the judicial proceedings, working alongside the judge, attorneys, and social workers as an appointed officer of the court for a particular case to help identify a child's best interests. The Commission trained all the New York State CASA directors to use the Checklist and the directors have trained their local volunteers. As a result, CASAs throughout New York State are using the Checklist and routinely incorporating a child's health and developmental needs in their reports to the court. In Erie and Westchester counties, CASAs are using the Checklist on every case involving a foster child under age 5. CASA involvement has encouraged judges to write court orders specifying health and developmental screenings and where appropriate, health and early intervention services for individual children. The CASA Project has facilitated the use of the Checklist and strengthened the CASA program, increasing its availability as a resource for judges.

In addition to the CASA Project, the Commission has

worked closely with several New York State judges to augment the role of their legal staff — court attorneys and court attorney referees. Court attorneys are judges' law clerks and court attorney referees are court attorneys with enhanced responsibilities comparable to magistrates. In New York, court attorneys can convene pretrial conferences and court attorney referees also can conduct hearings and make recommended decisions to the judge and, upon consent of the parties, decide cases that are subject to appeal to the judge. These attorneys and referees hold case conferences and hearings and use the Checklist as a tool to guide permanency planning and decision making. They have used the Checklist at pretrial conferences to obtain information about a child's health and development and to identify gaps in services for inclusion in case plan and court orders. Court attorney referees' most active role has been in the post-disposition phase (after the court has entered an order that places a child in foster care and also delineates specific services for the child and parent) by holding compliance reviews to assure that needed services are being provided.

Through its trainings and publications, the Commission has increased awareness about existing community resources, service delivery systems, and funding streams that can address and ameliorate the health needs identified by the Checklist.

The Commission also has used nonlegal resources to assist the court in implementing the Checklist. The Commission supervised master's-level social work students to help judges and court staff use the Checklist in reviewing case plans, shaping dispositions, and identifying unmet needs of children. In the New York County Model Court, the Commission earmarked Court Improvement funds to hire a master's-level social worker who asks the Checklist questions at pretrial conferences to identify service needs and issues that can affect permanency decision making. The Checklist questions also were incorporated into the Model Court's database to generate reports and to help determine trends. The Commission provided training to the Suffolk County Family Treatment Court team comprised of attorneys, CASAs, social workers, and substance abuse counselors. As a result, that Court has incorporated elements of the Checklist into their court order and drug treatment plan forms. In Westchester County, a part-time educational consultant funded by the Commission uses the Checklist to assist the judge in reviewing the health needs of school-age children.

A third challenge highlighted by the use of the Checklist was the gap in services to address the health needs of children in foster care. The Commission realized that focusing attention of all those involved in the court process on the health of children was meaningless if services to address their needs and to support their caregivers were inadequate or nonexistent. The Commission is developing strategies at the county, state, and national levels to ensure that services needed by children and their families actually exist. We have worked with several counties to bring stakeholders together to develop needed services. For example, in two counties, that effort resulted in the development of automatic referral mechanisms for developmental screens under Part C for all children in foster care under age 3.

Additionally, through its trainings and publications, the Commission has increased awareness about existing community resources, service delivery systems, and funding streams that can address and ameliorate the health needs identified by the Checklist. These include the early intervention program, special education system, and early childhood and family support programs such as Head Start, Early Head Start, the Temporary Assistance for Needy Families (TANF) funding stream, and a growing number of model programs that can be replicated. Commission staff also have provided consultation to early intervention officials at the state and federal levels, as well as urged the inclusion of children in foster care in mandated child find activities in the amended IDEA regulations and in proposals for reauthorization. Most recently, the Commission co-authored a policy paper with the National Center for Children in Poverty. *Improving the Odds for the Healthy Development of Young Children in Foster Care* (Dicker, Gordon, & Knitzer, 2001) brings together all our work by focusing on what government agencies, the courts, and other partners can do to improve the well-being of young children in foster care and describing pioneering models of health care delivery and developmental programs for these children. It has been disseminated nationally to policymakers and advocates.

The Success of the Checklist

As a result of the Commission's outreach and training efforts, judges, attorneys for children, parents, CASAs, and child welfare agencies nationwide are using the Checklist to identify the health needs of children in foster care. Most often, the information gathered is factual — whether the child has received a health screening, the specific results of a screening, and what services are being provided to address the child's needs. If the needed services are not secured, courts have entered orders. The following examples highlight how the Checklist is being used to focus attention on the healthy development of children in foster care:

- A CASA volunteer used the Checklist to determine that an infant had not received the mandatory comprehensive exam since entering foster care. The court ordered an exam and the child was found to have a tumor behind her eye. A court order facilitated an immediate operation which not only saved the child's

sight, but assured her healthy development.

- Use of the Checklist revealed that a 5-year-old had extremely high blood pressure, but had received no services to address the problem. The court ordered follow-up by a specialist. The child now is receiving critical treatment from a pediatric cardiologist.

Some involved in child welfare proceedings also are using the Checklist information to shape decisions about placement, visitation, and permanency. The following are examples of courts asking what supports a parent requires to meet their child's special needs and using this information to make placement, visitation, and permanency orders:

- A CASA volunteer was assigned to a case involving a young child with severe burns. The child's mother had a history of substance abuse and limited cognitive ability. Using the Checklist, CASA discovered that the child's burns required dressing changes several times each day and that need was used as a reason to deny visitation to the mother. CASA shared this information with the judge who entered an order specifying training for the mother needed to facilitate visitation and eventual reunification.
- Using the Checklist to inquire about a child's developmental needs revealed that an infant was receiving early intervention services at her foster home, but the success of those services was cited as a reason to delay reunification. Further inquiries by the court facilitated a change in the child's Individual Family Service Plan (IFSP) to allow services to take place at the home of the biological mother to facilitate the permanency goal of reunification. The child was soon reunified with her mother with all needed services. The judge estimates that the child was returned home months earlier due to the use of the Checklist.

The Checklist also has encouraged judges, attorneys, and child welfare agencies to make systemic change:

- Many courts throughout New York State are beginning to use the Checklist as a routine component of case planning. Judges and court staff routinely ask the questions at initial hearings and use the information obtained to shape orders and to form the basis for compliance reviews and permanency hearings.
- Judges in some New York counties have created a climate in their courtroom where answers to the Checklist questions are expected at each court appearance. As a result, caseworkers and attorneys are more often prepared with specific information about a child's health and development.
- The New York City Administration for Children's Services (ACS) now includes the Checklist in its permanency hearing form and requires that all health-related information be gathered and provided to the court prior to the hearing.

Health care and child development professionals can play a critical role in helping the courts translate information about children in foster care and their caregivers in ways to aid in decision making concerning placement stability, visitation, and permanency.

The Challenges Ahead

The Commission has identified issues that must still be addressed to achieve the full potential of the Checklist. First, the frequent turnover of child welfare and court staff requires ongoing training about the Checklist and making health and child development mandatory components of orientation and continuing education for caseworkers, lawyers, and judges. The Commission has provided training on the Checklist at New York State's Judges School, as part of every CIP training session, trainings for new Drug Court staff, and to caseworkers in parts of the state. Also, all new Family Court Judges and attorneys receive the booklet and accompanying materials. Second, the Commission has begun to identify and address the second-generation issues arising from the Checklist. Additional training and technical assistance must help those involved in the court process make the connection between health and development and permanency by answering these key questions: Given the child's needs and parent's challenges (i.e., substance abuse, cognitive limitations, mental illness), what supports will this parent require to care for this child? What are the red flags that may indicate that, even with these supports, a caregiver cannot meet their child's needs? In addition, the Commission has begun to develop questions that highlight the needs of particular groups of children in foster care such as infants and adolescents.

To answer these questions, courts and child welfare professionals require guidance from those who assess and treat children in foster care and their caregivers. Most often, service providers submit reports to child welfare workers who may or may not even share the information with the court. Yet, health care and child development professionals can play a critical role in helping the courts translate the information about children in foster care and their caregivers in ways to aid in decision making concerning placement stability, visitation, and permanency. Service providers and clinicians must develop strategies to disseminate their knowledge about individual children in foster care and their families to all those involved in the child welfare proceeding — caseworkers, attorneys for children and parents, and judges. The Commission has identified models of collaborative, formal partnerships between the courts and child welfare, health care and early childhood agencies (Dicker et al.,

2001). These models bring clinical information to the court and child welfare agencies. Yet, those involved in these initiatives report that bridging the gap between the clinical setting and the court continues to be the most difficult challenge.

Despite the communication gap between the health and court systems, most judges wish they had more meaningful information about the children and families in their courtrooms. The Commission staff has interviewed judicial leaders about the clinical information that is most useful to permanency decision making. These judges agree that the most helpful reports provide more than the raw results of evaluations. While most judges cautioned service providers against making conclusions about placement and visitation, all expressed a desire for detailed information in nonprofessional jargon about a child's daily needs, the impact of the child's health and developmental status on parenting demands, and the skills required of a caregiver to meet the child's needs. These discussions led us to identify the following information for inclusion in reports to the courts:

- a child's strengths and needs;
- specific illustrations of how a child's strengths and needs may impact a caregiver's ability to parent the child;
- the caregiver's mental capacity to understand the child's special needs;
- learning requirements for caregivers to meet the child's medical, dietary, developmental, emotional, behavioral, and educational needs;
- specific services and supports available to help the caregiver understand and address the child's needs;
- specific illustrations of the caregiver's ability to comply with special plans for the child including medical appointments, medication administration, and early intervention or educational meetings and participation in services;
- observations about the attachment between the child and caregiver and recommendations for services to enhance the child-caregiver relationship;
- concerns about the transportation of child to appointments and activities; and
- concerns about whether the caregiving environment can accommodate adaptive equipment such as wheelchairs and walkers.

Service providers and clinicians can best provide this information by citing specific planning considerations for a particular child. For example, sharing information about how a parent's limited literacy or cognitive skills may impact the parent's ability to administer medications to the child or to participate in IFSP meetings can shape court orders. Illustrations of the caregiver's compliance with medical appointments or the child's daily routines can be a guidepost for judges to determine visitation and placement. Informing the court and child welfare staff about a child's transportation and adaptive equipment requirements can prevent inappropriate initial placements and limit changes in placements.

By asking the Checklist questions, judges, advocates, and child welfare professionals have safeguarded the right to health care for numerous children in foster care. The Commission continues to advocate for wider use of the Checklist to uphold the promise of healthy development for every child in foster care. We hope that service providers will join our efforts to broaden the impact of the Checklist to enhance every child's prospect for growing up in a permanent home.

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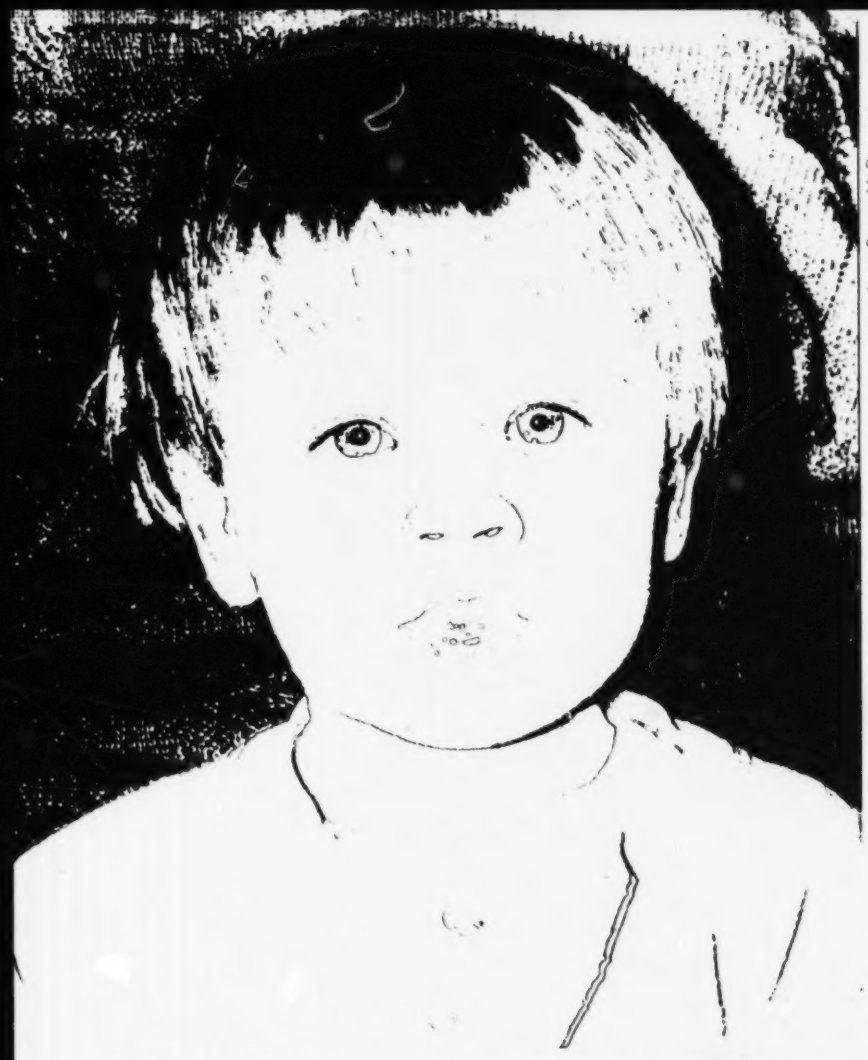

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PROVIDING MENTAL HEALTH SERVICES TO YOUNG CHILDREN IN FOSTER CARE:

A Family-by-Family, Moment-by-Moment Approach to Change

In 1998, a foster mother found us. She was a skilled, experienced foster parent who worked as a preschool educator for children with special needs, but the 18-month-old little girl now in her care was, in her words, "raging off the charts." This mother had heard about the Good Fit (Good Foundations for Families, Infants, and Toddlers) Center at Southwest Human Development (SWHD). Determined to pursue any resource that might help her understand and care for this troubled toddler, the foster mother called. We responded, and so began the Good Fit Center's provision of mental health services to very young children in foster care. Our work with these children and their caregivers has expanded over the past 4 years so that currently, in any given month, we are serving up to 100 children under 4 years old who are in foster care, in the process of adoption, or have finalized adoptions. This article will describe our family-by-family approach to providing mental health services to young children in foster care; the organizational and health care financing systems that support our work; our "at-this-moment" intervention strategy; and the emerging network of relationships that is bringing about important, positive changes in outcomes for children, the

at a glance

- The Good Fit Center at Southwest Human Development expanded its mental health services to young children and their caregivers gradually.
- Arizona's system of financing behavioral health services allows us to serve the child under 4 whose foster or adoptive parent, or case manager, sees that he is in difficulty and seeks our help.
- We treat foster parents as co-therapists from the time of our first contact.
- Trustworthy relationships within our team, with foster and adoptive parents, with CPS, and with the behavioral health system are essential to our work.

capacities of their caregivers, and the functioning of the health and social service agencies responsible for their welfare.

Good Fit Center's Developmental History

SWHD was founded in 1981, by Ginger Ward, the current Executive Director, as a nonprofit educational and human services organization. With a staff of 450, the agency now provides comprehensive services to approximately 30,000 young children and families who face challenges related to health, child abuse and neglect, mental health, poverty, and disabilities. Services offered through SWHD are provided through a family-focused relationship-based model that emphasizes families as primary decision makers and the enhancement of the family's capabilities as a way of improving their ability to negotiate services and obtain resources in response to their needs. The Good Fit Center began as a dream of a SWHD staff member to have a home-like place where parents in need of help with their very young children would feel welcome and listened to. After several years of planning, the Good Fit Center opened in 1996, with a start-up grant from the Saint Luke's Charitable Health Trust in Phoenix. This grant enabled SWHD to rent and renovate a building, and hire a manager and a psychiatrist to work with the internal management team of a psychologist and social worker with advanced training in infant and toddler mental health. Today, the Good Fit Center houses the entire Family Health and Wellness Department of SWHD and one team of the agency's Infant and Toddler Head Start staff. The Department has approximately 15 different funding sources and operates numerous mental health, nursing, training, and consultation programs that serve children from birth through age 5.

Elaine Groppenbacher joined SWHD in May 1997. Although she had experience in foster care and adoption of children with special needs, she didn't expect to focus on this population in the SWHD position. In February 1998, Sandie Miller joined our team – at just about the time that we were beginning to get steady referrals to provide services to 4- and 5-year-old children who had emotional and behavioral difficulties. Sandie came with 10 years experience as a child and family worker as well as trainer in the adoption of children with special needs, which gave our team solid grounding in the issues, attitudes, current practices, and possibilities of foster care and adoption. In 1999, Cindy Hoard joined our team bringing extensive experience assessing and working with children with special needs and their families and 8 years of experience working at SWHD. Busy providing outpatient mental health services to a varied group of young children, we didn't advertise our foster care expertise. Then the foster mother found us. The Child Protective Services (CPS) staff in this family's case management unit heard about our work. They began to make referrals. "You can do something with little kids?" they asked us.

The System That Supports Us

We can "do something with little kids" because of our team's infant mental health expertise, and also because of Arizona's system of financing behavioral health services. In Arizona, the majority of children from birth to 18 years of age who are in foster care are eligible for AHCCCS (Arizona Health Care Cost Containment System), the state's equivalent of Medicaid, Title XIX. A child enrolled in AHCCCS who has a behavioral health problem can get care through regional behavioral health authorities (RBHA) which contract with the state health department's Behavioral Health Services Division to provide mental health services in the various Arizona counties. For Phoenix and surrounding areas located in Maricopa County, the RBHA is ValueOptions, a managed care organization. To receive services, a child in foster care must have a behavioral health difficulty (demonstrated need) and consent from the legal guardian (CPS) for evaluation and treatment. Because of rules governing subsidies for children with special needs and "pre-existing risk factors," (documented challenges and risk factors that pre-exist the finalized adoption), most of the children we serve remain eligible for behavioral health services under AHCCCS if they are adopted. Children who return to their birth families may remain eligible for these services if their families meet income guidelines. The key point is that this financing system allows our team to serve the child whose foster or adoptive parent, or case manager and legal guardian, sees that he is in difficulty and seeks our help.

Child Protective Services doesn't pay our bills – to CPS staff we are a resource, not a vendor. Behavioral Health Systems does pay our bills. It is important to note that, in the region in which SWHD is located, carefully nurtured relationships between the Good Fit Center and the behavioral health system have led to mutual respect and an increasingly sophisticated appreciation on the part of the system of the cost-effectiveness of skilled assessment and relationship-

focused treatment of very young children's mental health problems. Our job, then, is to make sure that we are able to blend our expertise in working with very young children and families with our growing experience in working with foster and adoptive parents, so that we provide the most effective assistance possible to children in extraordinary distress.

What Do We Do?

In evaluating and treating children under the age of 4 who are in foster care and referred to us because of emotional and behavioral problems, we recognize the extremity of their situation. We also look for evidence of resilience. We believe that any positive relationship will have a positive impact on a child's immediate and future well-being. We do our best to ensure that young children in foster care will have an ongoing, positive relationship with their parents or primary caregivers, and we appreciate the value of our own relationships with the children we serve.

Children come to us because someone notices that they are struggling; someone cares. Someone – usually the foster parent, but often a CPS case manager – thinks that we can help. In the context of foster care, this child-by-child, family-by-family referral process provides a sturdy foundation for a relationship-based approach to evaluation and treatment. Foster parents come to us because they want to, not because they are ordered to. We work as partners with foster and adoptive parents, trying to understand the child and her caregivers at the moment we meet them. Regardless of what the child has experienced in the past, the child is expressing something through her behavior now. And this behavior may or may not be related to the child's past experience. So, what is the child trying to tell us? How can we help?

In the assessment process, we try hard to avoid making assumptions. Our job is to sort information and make sense of the child's behavior in light of not only past, but current experiences. We talk to the foster mother. We watch the child. With young children in foster care, we must take a comprehensive look at the many factors influencing a young child's developmental status and be alert for unusual patterns of strengths and vulnerabilities. Not infrequently a child will do well on a Bayley developmental examination or a speech-language test but show limited social and emotional skills.

Our approach to foster parents illustrates the principle that "assessment is intervention." We treat foster parents as co-therapists from the time of our first contact. We start by asking for their perceptions of the child and what he is coping with. How is this child "ticking"? What is she trying to tell you through her behavior? We assume that at this moment the foster parent is the authority on the child. We are not doing a family assessment — a process one foster parent described to us as "having to take all the skeletons out of your closet and display them on the front lawn, just to get the job." Rather, we recognize that, in the case of foster and adoptive parents, someone has already made the decision that this family can meet the needs of the child in their care. To experienced foster parents who may express some degree of cynicism about any service or professional connected with the child welfare system, we may say quite explicitly, "I will believe whatever you tell me about the child and your own family until I have concrete evidence to the contrary, at which point I'll talk to you about that."

Respect for the foster parent's perceptions lays the foundation for much of our work – that is, reframing the child's behavior. Once foster or adoptive parents begin routinely to ask the question, "What is this child trying to tell me through his behavior?," they see the child from a new perspective. They can take in and process the child's behaviors differently; they can see that a socially unacceptable behavior may be a positive coping mechanism for the child. Prolonged tantrums or "falling apart" after a visit with a parent may still represent challenges to the foster parent, but they may no longer be a barrier to the relationship itself. Together with foster and adoptive parents we wonder: What can we do to help the child settle down? What can we do, in the context of the child's daily life in the foster family, visits with parents, and progress through the child welfare system, to offer experiences of positive relationships, to help a child feel good about himself, and, bottom line, to help a child know that he is safe?

Within the "comfort zone" we create over time, foster and adoptive parents often take advantage of opportunities to talk about their own experiences and concerns; how caring for this child impacts them individually, as parents, as well as their family. Especially when reunification efforts are underway, foster parents may feel abandoned. We value and validate their perceptions. We tell them that it is good for them to become attached to a child in their care and support them as a child is reunified with parents or adopted.

Although children must be younger than 4 years old to begin working with us, we can see them and their caregivers as long as they are in need of service. This frequently gives us several years to work with a child and family, teaching foster and adoptive parents what they might expect as development unfolds, and how to advocate for the child. We have come to appreciate what it means to work with a family in a moment in time, dealing with the issues at hand. Especially when children have experienced significant trauma in the past, everything may not be resolved quickly. If a family wants to "take a break" from treatment, we can stop and resume later. Foster parents are prepared for "issues," and we can let adoptive families know that as a child develops, unresolved issues may re-emerge. Hopefully, the parents will emerge knowing that they and their family are the therapists for the child, and realizing that support is there if they need it. We can feel satisfied when we have done what we can at this moment in time.

Relationships and Their Ripple Effects

Although the behavioral health care financing system within which we work considers the child as an individual — the identified client and recipient of services — we recognize that a child functions in the context of relationships. The trustworthy relationships we have built — and work hard to maintain — within our team, with foster and adoptive parents, with CPS staff, and with colleagues in the behavioral health care system all help to support and strengthen children's important relationships.

Relationships within the team. Each member of our team brought considerable expertise and experience to the work but we have also worked hard to make sure that staff have gotten additional training to develop their skills. Every counselor has a primary supervisor (Elaine, Cindy, or Sandie). Everyone on the team can go to each other for informal consultation, and Good FIT's consulting psychiatrist is accessible as well. In our team's culture, saying we are stumped is a sign that we appreciate the complexity of the work. The close relationships within our team provide much-needed emotional support for staff. Our greatest challenges are often not clinical ones. Despite our best efforts, a decision within the child welfare system may leave a child dangling; a therapist may walk out of a CPS staffing or a review board hearing feeling totally powerless. If her primary supervisor is not available, a staff member is welcome to talk with anyone on the team. When necessary, we remind each other that on some days it's hard to keep a positive attitude. Sometimes you have to "cry uncle" for the day – and come back tomorrow.

We see foster and adoptive parents as the true agents of change for the children in their care. We also work hard to build respectful, responsive relationships with CPS case managers.

Relationships with foster and adoptive parents. We see foster and adoptive parents as the true agents of change for the children in their care. As noted earlier, we treat foster and adoptive parents as co-therapists from the time they first contact us with their concerns about a child. They are the people who have noticed the child's distress or atypical emotional development, and they have come to us because they believe change is possible. Through our working relationship on behalf of the child, we try to help foster and adoptive families understand the meaning of the troubled child's behavior and how best to meet the underlying needs he is expressing. Hopefully, we assist the parents in coming to a greater understanding of who and how they are in this process. We also pay attention to foster and adoptive families as a whole. For example, we acknowledge other children and may involve them in the treatment process, saying, "Billy, you're 5 years old; here's what you can do to help Ginny, who is only 2." Families appreciate our attention to all their relationships.

We share what we have learned clinically with foster and adoptive parents so that they can use this knowledge not only with the child we are currently seeing but with the other children they will care for. In turn, we have learned much from them and apply it to our work with other children and families. We often serve as a bridge to additional services in the community that children and families may need. To help foster and adoptive parents become more knowledgeable and effective advocates for their children, we offer them the experience of being "at the table" with psychiatrists, directors of preschools, and other community service providers. We can see the ripple effect of our relationship-building when foster families come back to us with another child in distress.

Two additional points are worth making about our experiences working with foster and adoptive parents. First, although the young children in foster care who come to us are often exhibiting quite worrisome behavior, they are generally dealing with the impact of an extreme situation, such as removal from a home in which they experienced significant abuse or neglect. In the care of solid, stable, concerned foster and adoptive parents, these children may have an easier time overcoming emotional difficulties than many of the troubled infants, young children, and families who come to us with mental health problems. Second, because we are not providers of adult services within the managed behavioral health care system, we can not offer treatment to birth parents, who may get services from a host of different providers. With the child as the focus of our services, we try to be available to help birth families make things easier for the child, and we work with a handful of families who are caring for relatives' children in informal mechanisms outside the Child Protective Services system. But in our community, the behavioral and mental health system still consists of an adult system and a child system; in structure and in practice, it does not yet recognize the importance of relationships and family.

Relationships with Child Protective Services (CPS) staff. In our experience, the CPS case manager can sometimes seem like the most powerless person in the entire child welfare system. She is likely to be new at her job (the turnover rate is extremely high); she has few resources at her command; and her decisions can be overturned by her supervisor or the court without explanation. We reach out to CPS case managers in the same way that we approach foster and adoptive families, with the basic question, "How can we help you help this child?" For example, if we find that a child in foster care is not enrolled in AHCCCS, we never suggest that the case manager hasn't done her job. Rather, we let her know

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that the child is eligible and ask how we can help make sure the child becomes enrolled.

CPS case managers work in such a difficult environment that our most ordinary acts of professional courtesy – returning phone calls, showing up for a staffing – earn extraordinary gratitude. Moreover, we are more than willing to have a 30-minute conversation with a case manager about what's on her mind. Although we are careful not to overstep the boundaries of our role, we can offer CPS staff rare opportunities to reflect on their work. We hope, of course, that the respectful, responsive relationships we try to build with CPS staff will come to serve as a model for collegial relationships within the system, and for relationships with children and families.

We are consistently at the table with other social service and behavioral health providers, child-serving state agencies, and advocates and seen as a willing partner in addressing systemic issues and challenges even though the focus of such may not be very young children.

Relationships with the Behavioral Health System. We use everything we have learned about building strong relationships on behalf of very young children in our roles in the behavioral health system. We are consistently at the table with other social service and behavioral health providers, child-serving state agencies, and advocates and seen as a willing partner in addressing systemic issues and challenges even though the focus of such may not be very young children. The idea that helping a young child with emotional or behavioral problems happens by partnering with families – by putting parents in the driver's seat – represents an enormous shift for a system that is based on deciding whether an individual adult or child requires "services" and then paying for those services. Yet the idea that children develop, function, encounter difficulties, and heal in the context of relationships is taking hold among decision makers in the state behavioral health care system, as we work together, case by case, and learn from each other. One signal that decisions makers in the AHCCCS and the Behavioral Health Services system understand and appreciate the complexity of work with children in foster care is the recent ruling that providers can be reimbursed for "case management time" — the hours spent making phone calls, writing and filing reports, and attending staffings and foster care review board meetings. Our agency absorbed the considerable costs of this work for the first 3 years that we served young children in foster care as part of the behavioral health system. As a result of this shift, our staff can serve these children in a more thorough and comprehensive manner as members of the child welfare team, without financial risk for the agency. Hopefully, other providers in the community will realize how this shift can make it possible to serve these children more effectively.

Closing Thoughts

As the referrals for foster children started to steadily increase in early 1999, we realized that working effectively with these children meant that clinicians would have more to do and more people with whom to interact: write quarterly status reports; attend staffings, Foster Care Review Boards, and court proceedings; observe visitations; meet with the multiple parties who each cared for the child but who may have had different agendas. At the time, much of this work was not reimbursed, although it is now. I remember convening a staff meeting. I presented these dynamics and simply stated to the staff: I need to know what you want to do. . . . Working with these children may consume a great deal of time above and beyond your typical workload — time for which we may not be reimbursed. Because we are not seeing that many young children in foster care yet, we can stop now and say we can't do it. Or we can continue, knowing fully well that the more children we serve, the more referrals we will receive because of the way we approach our work, the child, the family, and the other people involved. The staff had no discussion. The overwhelming response from each staff member was to continue on — because who else would serve these kids? So, family by family, moment by moment, we have done just that.

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PHOTO: ZERO TO THREE

WORKING TOWARD RELATIONSHIP-BASED CHILD WELFARE PRACTICE:

The SEED Model After 5 Years

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Two-year-old Crystal was discovered abandoned in a hotel room. In her hand was a photo of her mother and father. No one knew how long she had been left to fend for herself. For weeks she would speak only in a whisper; her pain held tightly inside. Yet her inner experience was reflected in her eyes. Her child welfare worker described feeling haunted by those eyes, she described them as "old" revealing a depth of experience way beyond her years – trauma beyond anyone's years.

Crystal was one of the first children to be randomly selected into the SEED Project (Services to Enhance Early Development), funded by the Stuart Foundation, which began in 1997, in Oakland, California. SEED is an innovative service model for young children in foster care that is based on a collaboration between the Center for the Vulnerable Child (CVC) at Children's Hospital and

Research Center at Oakland (CHO) and Alameda County's child welfare agency. From the outset, SEED had two major goals: 1) improving the placement, development, and mental health outcomes for the 100 children served directly by the Project; and 2) making lasting changes in the child welfare system that served about 1,200 Alameda County infants and toddlers in foster care every year. The initial 100 children were randomly selected from the children, ages birth to 3, who entered Alameda County's foster care system during the years 1997 and 1998. Ninety-five of the original 100 children are now permanently placed. (It should be noted that while we are pleased with this outcome, we unfortunately do not have a satisfactory point of comparison due to the child welfare system's inability to provide accurate data on the control group. Efforts are being made to correct this in order to track the permanency of the placements of both groups.)

SEED aimed to create and implement case plans that were driven by the unique needs of each child, and to promote early permanent placement of children. SEED's multidisciplinary team met weekly and included child welfare workers, a public health nurse, and CVC child development and mental health specialists. The child welfare workers on the team were made up of a specialized unit of child welfare professionals who had reduced caseloads that they carried from the child's entrance in the system to their exit. Each child in SEED was given a developmental/mental health assessment at least annually, and CVC clinicians provided mental health and parenting services such as parenting groups, home visits, and infant/parent and child psychotherapy.

A testament to the program's success, despite major obstacles along the way, is that today there are two specialized SEED units serving a total of 160 children from birth to 5 and a commitment by the agency to further extend the SEED model into Alameda County's Department of Children and Family Services. In this article we will describe the evolution of the SEED model and the lessons learned about the complexities of working within the child welfare system.

at a glance

- SEED is a model for serving young children in foster care based on a collaboration between a children's hospital and a county's child welfare agency.
- The SEED team includes clinicians, a public health nurse, and child welfare workers with reduced caseloads.
- SEED's relationship-based child welfare model is continually evolving.
- SEED began by serving 100 children; now two units serve 160 children from birth to 5 and further expansion is planned.

Model Formation

The SEED vision of improved outcomes was based on the primacy of establishing early, positive, permanent placement for infants and toddlers in the child welfare system as well as responding to the children and families' need for more timely and appropriate case management, assessment, and therapeutic services. We began with certain premises based on the lessons we had learned from years of working with children, caregivers, and the service systems with which the children and families were involved:

1. We chose a preventive approach, focusing on the youngest children in the child welfare system and involving ourselves with children as soon as they entered the system.
2. We wanted to create a voice for the children that was informed by an understanding of early child development and mental health, the importance of looking at and working with the child's relationships, and an understanding of each child's uniqueness.
3. We were committed to developing an ongoing, genuine collaboration between CVC and the child welfare agency.

When we began SEED in 1997, CVC had already developed a working relationship with Alameda County's Department of Children and Family Services based on our overlapping caseloads of children in the child welfare system. Since 1989, CVC had been providing mental health and family support services to this population of children and their caregivers. Many child welfare workers were familiar with CVC and relied upon our staff to provide critical services that they were unable to offer. In serving children and families involved in this system, CVC staff attempted to engage with the child welfare worker so that the child's and family's case plan and services were coherent and meaningful. Toward this end, CVC child assessment information and recommendations were given to child welfare workers. However, the responses of the child welfare workers to these CVC efforts at collaboration were highly variable. A small number of workers were committed to regular consultation and communication with CVC on behalf of clients and most were interested in accessing the enhanced services that we could provide. Many workers, however, were hard to connect with and some were almost impossible to reach. Most of the time our recommendations were not utilized and, instead, the developmental and mental health assessments of children seemed to be used by the child welfare workers as an end in themselves, rather than as a means to an end. Rather than using these assessments as a way to understand a child and determine services needed, it often seemed that the assessments ended up as little more than additional papers in an ever expanding file and, most unfortunately, as evidence that a significant service had been completed for the child.

Before the establishment of SEED, frustrated CVC staff tended to blame child welfare workers and "the system" for the inadequate and fragmented services received by our

shared clients. In retrospect, we were better able to understand what seemed like child welfare workers' lack of responsiveness. Child welfare workers have very large caseloads, few treatment resources, and are accustomed to working on their own without much collegial support or supportive supervision. Furthermore, despite our best intentions, CVC was probably perceived by many of these independent and overburdened child welfare workers as an intrusive outside agency that was making unrealistic and difficult-to-implement recommendations. Although CVC's caseload did overlap with that of the child welfare system and we were able to provide additional resources to clients, we had not developed the necessary trust or the leverage to be effective partners.

SEED allowed us to develop a team of committed and determined professionals who were ultimately willing and able to develop respectful and mutually supportive relationships with each other. The child welfare workers, with reduced caseloads and a supervisor who supported the philosophy and goals of the program, joined an integrated SEED team, consisting of CVC clinicians and a public health nurse. The mutual support, sharing, and learning that developed over the course of the project was extraordinary. Through participation in the collaborative team, child welfare workers learned more about early child development and mental health and integrated this knowledge into their practice. CVC staff learned about the very difficult role of child welfare workers, their legal mandates, and their court reporting responsibilities. Over time and through working together with the complex caseload of children and families, we became a real team of clinicians able to share and understand one another's perspectives and to respect each other's roles and expertise. Additionally, we all seemed to develop a new way of doing what our individual training and expertise had prepared us to do. As in the oft-told metaphor of seeing the elephant as its part – a tail as elephant or a trunk as elephant – we were now a little closer to having a sense of the whole "elephant." Together, we developed a more honest and complete picture of the complexity of issues. We learned to struggle and be creative together, doing the best that we could for each child.

An assessment of each SEED child's mental health and development at entry to the program, to guide case planning from the outset, was the starting point for focusing on the child in team discussions and planning.

We want to create a safer, more predictable, and more consistently nurturing world for vulnerable young children and families — within and beyond the foster care system.

The Role of Developmental Assessments

Although the child welfare system places children with appropriate relatives when at all possible, this process was slowed by the fact that 2-year-old Crystal's identity was not immediately known. She was, therefore, initially placed in foster care with a young single parent. Ms. F. was filled with love and sympathy for this child. For probably the first time, Crystal had healthy, readily available food, a bed to sleep in, a predictable routine, and an attentive parent. Ms. F loved to dress Crystal in pretty clothes and show her off to her friends. She was happy when this child, who had suffered so much, smiled and would tease her when she cried or became angry, commenting on the ugliness of a sad or angry face. She tried to help Crystal with her fears of sleeping and bathing and her quick tantrums. She gently coaxed her into the bath and made it fun, warm, and without pressure. Pained by what she felt to be Crystal's anguish in a tantrum, Ms. F latched onto what worked to make that helpless feeling in herself go away. She quickly found that if she left the room and said she did not want to be with someone who acted so badly, Crystal would stop the tantrum immediately, running after the foster mother to re-establish proximity or freezing in place.

The CVC psychologists set out from the beginning to bring the children and their voices to life for the team. The psychologist did the initial assessments after the child was settled in the foster home. The narratives that resulted from these assessments created a vivid picture of each child for the team. The number of visits depended on what was needed to get a reasonable and accurate understanding of the child. A newborn assessment could often be done in one face-to-face visit, while to assess a toddler, three to five separate visits were often required. The assessments utilized the Functional Emotional Assessment Scale created by Stanley Greenspan (1992) and were based primarily on clinical observations of the child interacting with the caregiver as well as some direct interaction of the assessor with the child and the caregiver.

The assessment philosophy embraced by the SEED model has been one of looking at children as a whole as they function in their natural worlds – and in particular in relationships. Individual lines of development, such as cognitive, language, and motor development, have been looked at as they transact with the environment (again with a particular emphasis on the relationships) and as moderated by the child's regulation capacities, temperamental styles, and affect. Assessments are done collaboratively with the caregivers – a process that encourages caregivers (sometimes new to the child) to be curious and interested in reading the child's cues and really knowing the child. The Functional Emotional Assessment Scale has both inspired and suited this type of assessment.

The assessment results in a narrative about the child and the child's interaction with the caregiver. We have attempted to use SEED assessments and the resultant narrative to make children's voices loud and clear in order to

inform and impact decisions made by child welfare workers, the child welfare agency, and the courts. The narrative is brought to the team as a starting point for child welfare case plans as well as treatment plans. The information gathered helps the child welfare worker know and understand children in a way that would have not otherwise have been possible given traditional child welfare practice. Through the life of each case, the assessments, reassessments, informal visits by the assessor, and the assessor's clinical expertise inform decisions made about children's placements and transitions as well as recommendations made to the court. Additionally, reports are written directly to the courts and the assessor is available to provide consultation to the attorneys related to the case. These assessments also form the basis from which referrals are made and through which treatment with SEED clinicians begins. Such referrals may include directing children to early intervention services for developmental concerns, or to specialists such as occupational and speech-language therapists or mental health professionals.

Equally as important, the actual assessment process has served to enhance the relationships between children and their primary caregivers who may be the biological parents, relatives, foster parents, or adoptive parents. Using an approach to assessment that evokes the interest and curiosity of the caregiver about the child results in an assessment that does not simply impart knowledge; knowledge is developed through the process itself. Additionally, the knowledge engendered through the assessment process can empower the caregivers as partners in understanding the child in their care. As such the assessment can support the caregiver's role as a parent and as advocate and can encourage and support a growing attachment to the child.

Ms. F welcomed the assessor into her home. By watching their interaction and talking to Ms. F, the psychologist was able to recognize the bond that was developing between Ms. F and Crystal. She was able to identify the gifts Ms. F was giving to Crystal in her loving interaction and regard for her as well as to respectfully consider some inadvertent negative messages Ms. F seemed to be giving to Crystal. The report noted "Ms. F is clearly in love with this child. As she describes, Crystal has brought her joy and happiness. This experience is demonstrated in the joyous, enamored responses she has towards this child. She is engaging and stimulating, animated and happy when she engages with Crystal. She is affectionate and engages in reciprocal back-and-forth interactions with Crystal. For the most part, she responds to her at a developmentally appropriate level and allows for her independence. She often seems to be able to take a positive approach in guiding Crystal." The report goes on to note that Ms. F takes on a teasing style with Crystal at times. While there is a recognition that it is done with loving intentions, it is suggested that Ms. F be helped to think about this style in terms of how Crystal perceived this experience given her developmental stage and personality and, particularly, her traumatic past.

Additionally, the issue of walking away during tantrums is addressed respectfully yet directly. While understanding the foster mother's motivation in this approach, the psychologist also clearly stated that, "Another approach should be taken in these circumstances…(this approach) works only because it is triggering such fear in Crystal that she immediately turns off the behavior and responds to fear of loss of protection and of abandonment. Instead Crystal's emotions should be validated, explored, and accepted while ultimately her behavior can be redirected." Ms. F learned from the assessment that Crystal was extremely vulnerable emotionally to anything that felt like abandonment.

In the course of play, the caregiver was also surprised to see that Crystal liked to play with dolls and readily engaged in themes of nurture. She saw that any conflict or threat brought into the symbolic play paralyzed Crystal initially and then led to the seeking of comfort from the foster mother. She was able to see how Crystal had learned to defend herself by hypervigilance to incoming information and by subsequent filtering of information as to whether it threatened her safety or not. She saw how Crystal speaking in a whisper was another form of self-protection. This assessment experience enhanced the relationship between this caregiver and child and aided this opportunity for Crystal to have a positive attachment and reflection of herself as having value.

The information in this assessment allowed the team to be thoughtful about who Crystal was and how she would experience changes in her life. A short time later when she was placed with her adult cousin, the transition was driven primarily by this particular child's needs and not solely by those of the system or the adults. The team was able to know and respond to the emotional needs of this child during this transition and to respect and encourage the relationships of the various caregivers with Crystal.

Treatment

As mentioned above, a variety of treatment forms have been available through SEED. The case manager, the first to bridge the gap as the team members from the child welfare agency and CVC began creating the steps in the dance of collaboration, provided needed services that were recognized and respected by both the clinical and child welfare worlds. Supporting and enhancing the services of the child welfare workers, she provided help in negotiating the medical, educational, social, and developmental service arenas as well as provided family support and developmental guidance. The public health nurse was also an invaluable resource to a multidisciplinary team. She brought a unique perspective on the cases and provided an understanding of medical issues to the team as well as being accessible through home visiting to families and through consultation to child welfare workers to address medical and developmental concerns. Her warm

style as well as her role as a nurse allowed her to develop relationships with many relative caregivers who we have often found to be more difficult to engage.

The psychologists' interventions included assessment and consultations, as described above, as well as short- and long-term interventions. The short-term interventions usually resulted from findings in the assessments. In these cases, assessments led to ongoing home visits with caregivers (foster and biological) to discuss developmental concerns, to work with temperamental mismatches between caregiver and child, to help support a caregiver struggling with regulatory problems in a child, or to help a foster parent or prospective adoptive parent get to know and understand their child. In this way we have attempted to promote healthy attachments with current caregivers. Long-term interventions have included supportive guidance around developmental and parenting concerns or challenges, individual therapy with children who may have entered SEED at age 3 and were now 3 to 6 years of age, and infant-parent psychotherapy with a small number of reunifying parents.

Unfortunately, Crystal's placement with her adult cousin was fraught with unforeseeable problems. As her cousin became increasingly overwhelmed, so, too, did Crystal. Her tantrums increased in duration and intensity. Her cousin, in her guilt for not being able to care for Crystal, increasingly protected herself emotionally by seeing Crystal as a lost cause. This placement was several counties away. Our attempts to help, including assessment and support as well as a referral to a local therapist, ultimately failed. After a little less than a year of living with her cousin, Crystal's child welfare worker was given 2 weeks by the cousin to place her elsewhere. Crystal was being given constant unintentional but unmistakable messages that she was too much, uncontrollable, even unlovable.

The team was determined to find a foster home that was willing and interested in adoption. When a potential family was identified we were able to spend a great deal of time with them describing Crystal and what they might face in getting to know her and raise her. We were able to be integrally involved in the transition. We started her immediately in a therapeutic nursery school that recognized and nurtured her strong cognitive abilities and that handled all of her emotional upset with calm expertise and aided her in developing emotional regulation and a positive sense of herself. The foster parents were provided family therapy and parent guidance through the coordinated efforts of the therapeutic nursery school and the SEED psychologist. The psychologist provided weekly psychotherapy for Crystal. The child welfare worker was involved always as a collaborative member of the clinical team.

The Role of the Child Welfare Worker in SEED

A major focus of the SEED model is on the role of the child welfare workers. Their pivotal role in the model has undergone continual refinement and evolution. Two changes from the outset were to reduce caseloads from more than 30 to only 20 children and to have the same child welfare worker see the case through from beginning to end. The latter was an important change from the traditional model in which the child welfare worker is changed depending on the status of the child's legal placement. Probably in a conscious or unconscious effort to protect the child welfare staff from the pain of this work, the traditional child welfare system operates in an "assembly line" manner. The child has one worker when the initial investigation is begun and is passed onto another worker for reunification services or for family support or maintenance services and finally passed onto another worker if an adoption results. In SEED, alterations in this practice were implemented to encourage the development, and support the importance, of the ongoing relationship between each child welfare worker and her/his clients. Additionally, in this model there was a shift for the workers from their usual solitary approach to one of working within the team. This was difficult at first but became a source of support for workers, as the trust and communication of the team developed over time. Additionally, and perhaps most dramatic, was how all of the above elements resulted in such a different form of child welfare work. Child welfare workers had the opportunity to truly know the families and caregivers involved and to come to respect the role of their relationships with families and caregivers in a way that would have been considered a luxury when caseloads and role demands were higher and the workers were using only their individual resources.

This new child welfare role did not come without a price. Working with these children and families and their tragedies is a highly demanding job both practically and emotionally. The reality of these children's lives can be unbearably dismal at times. The reality of the parents' lives and the circumstances of the communities served can also be painful to witness. Carefully thought-out and implemented team recommendations could be disrupted by court decisions, made from a different perspective.

One child with whom we had worked had been placed since birth in an exceptional foster home — which was open to adoption, if possible — and had experienced minimal and inconsistent contact with her biological mother. However, the child, not quite 2, was returned by the judge at the time of hearing to her biological mother with no transitional period or time to say good-bye to her foster mother. The spirit of this amazing child and the tenacity of the early attachment are remarkable. Over a year later, after anguished and futile attempts on the part of not only the foster mother but the involved members of the SEED team to let the child see the foster mother and to open communication between the biological and foster mothers, the child and her foster mother ran into each other by chance. The child gasped to see her other mother. She knew her immediately. She touched her and said she wanted to show her something. Around the

child's neck was a little purse, which she opened to reveal the contents – a single tube of chapstick. The foster mother recognized this immediately as a symbolic recreation of the special tube of chapstick she always kept in her purse just for this little girl. This child had clearly managed to find her own way of keeping her foster mother with her.

Evolution of a Relationship-Based Child Welfare Model

As we begin the second phase of our work with a new group of children, we can incorporate changes that we have learned from the work itself and address the difficult, frustrating challenge of balancing this population of children and families' enormous need for services with the available resources.

A Model of Relationship-Based Child Welfare. The SEED model works toward the development of case plans that set goals that make sense for individual families, and the use of specific and appropriate services that can offer the prospect of making some real changes in the lives of children and families. The model is very different from a case plan with simplistic goals that biological parents are expected to follow to the letter. The model enhances the child welfare worker's relationship with the families and role on the team, bringing people together with the child at the forefront of everyone's thinking. The voices of the children, that we as mental health and developmental specialists have tried to interject, become louder and more integrated into the child welfare and court systems. As this program moves from pilot to large scale within the child welfare agency, a program of training and consultation in the SEED model will be made available to all Alameda County child welfare workers and supervisors who serve children birth to 5 years of age.

A New Approach to Screening and Assessment. We are developing a more individualized and fine-tuned approach to screening and assessment, with improved monitoring of both the progress of the children in our program and of our own efforts. In order to formulate an initial treatment plan for each child at team intake meetings, child welfare workers will use a new protocol to guide them through initial home visits with biological families and caregivers. The information they will provide will be expanded from information such as case history, legal issues, and case management concerns to include such clinical issues as how the family is experiencing the crisis of removal and also will provide insights into the functioning and concerns of the biological family. An initial screening interview by the CVC clinician or the public health nurse will include an overview of the child's development, regulation, temperament, and relationships with their caregivers. The instruments used will include the Ages and Stages Questionnaire (Squires, Potter, & Bricker, 1999) and the Infant Toddler Symptom Checklist (DeGangi, Poisson, Sickel, & Wiener, 1995) as well as an observational guide to the interaction between parent and child. These instruments will be adapted to be interactive and observational and completed jointly by caregiver and assessor with the child. Any questions that may be worded in a pathologizing direction will be explored in a more open-ended way. These screenings are meant to give a snapshot view of the children and their functioning in relationship with their current caregiver. The information gathered is used as an initial guide to treatment planning and not thought of as static or defining in any way. We are particularly aware that much of what we may be seeing at this initial point may be a reaction or adaptation to a traumatic period of removal and placement.

The screening will follow SEED's assessment philosophy: We will look at the child's overall functioning by observing the inter-relatedness of multiple areas of development and will seek to bring out the best of the child's functioning in a mutual exploration with the caregiver (biological or foster parent), using and respecting the caregiver's knowledge of the child. The screening will also involve gathering as much information about the child's birth and developmental history as possible as well as the biological family's health history. This is the kind of information that far too often gets lost or repeatedly misrepresented from report to report for too many children in the foster care system (see Silver, this issue).

Four Service Options. While our preference would be to offer all services possible to each child and family, SEED must balance needs and available resources. In its initial intake meeting, the SEED team will decide which of four possible service options to provide:.

1. The child welfare worker, trained in issues of child development, attachment, and infant mental health, will receive consultation from the SEED team. Children may be referred to outside agencies for developmental or mental health services.
2. The public health nurse or CVC case manager will provide ongoing case management and/or parent guidance and support for foster and biological families.
3. CVC psychologists will provide a full, individualized assessment and short-term treatment.
4. CVC psychologists will provide intensive therapeutic services to a small group of reunifying families for whom there is a clinical determination of reasonable potential for engagement. The treatment possibilities will include infant-parent psychotherapy, individual therapy, and developmental guidance and support.

The decision-making process as to what services will be offered to whom will be monitored carefully. Each case will come up for team review every 4 months. Through this systematic review, any change in a child's circumstances or in our understanding of a case will result in revising the plan. Additionally, through these reviews, we can continually re-evaluate how we are deciding which form of treatment we are offering for which children and families. While this plan, in part, was designed with resource limitations in mind, it will ultimately be a model that increases the

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autonomous use of clinical relationship-based and child-oriented thinking on the part of the child welfare workers. It is hoped that through the incorporation and growth of the model, this type of thinking and work will influence the agency as a whole.

Collaboration with the Juvenile Court System. As SEED has developed, we have also become increasingly aware of the need to collaborate more closely with the juvenile court system, including the judges, children's attorneys, attorneys for the child welfare agency, and the public defenders who represent the children. We have provided consultation on infant and toddler development, attachment, and mental health to the Office of the Public Defenders, who are the children's counsel in this county. We have provided training to the judges and commissioners who are the bench officers in these dependency cases and we are working to continue ongoing relationships with them. We plan to collaborate more with county counsel, who represent the child welfare agency in court.

Lessons Learned

Five years of working together to make SEED take root have taught the Center for the Vulnerable Child and the Department of Children and Family Services in Alameda County that the following components are essential to create, sustain, and gain support for expansion of this model:

- a collaborative multidisciplinary team within which relationships and process are respected;
- reduced caseloads for child welfare workers;
- initial and ongoing leadership and support for clinical child-focused child welfare work;
- assessments that serve as a basis for case planning and that evaluate children's mental health, development, and relationships by joining with caregivers to look at the complex transactions of multiple influences on a child's functioning; and
- interventions designed to strengthen children's relationships.

The most important elements in establishing this collaborative relationship were the initial and ongoing support for the SEED model from leadership at the director and supervisory level within the agency, and CVC's ability to provide some of the crucial and scarce case management, mental health, and developmental services for the clients that we shared. Equally important was persistence in creating a team that really worked together – with child welfare workers and CVC staff acknowledging that we had as much to learn from, as to teach each other. The CVC clinical supervisor and the child welfare supervisor were equally dedicated to working toward this vision. Child welfare workers became intrigued by the child assessments that painted vivid pictures of the very youngest children. They listened to and began to appreciate the value of CVC staff's expertise in making effective case plans. Importantly, the recognition of the ambiguity of this work in which there are rarely easy answers and almost always insufficient resources became a sort of glue that held the team together. Over time and through this process trust was built and the benefits of the information sharing and mutual support became clear and increasingly valued by all team members.

A culmination of our increasing ability to trust each other and work together came as we recently conducted thoughtful reviews of some of the most difficult cases in order to examine and better understand what we did and ways we could have done better for the clients. It was abundantly clear that the team is now willing to struggle together and sit with the hard questions, to openly discuss what happened or didn't happen for children and families, and to examine their own part in how things turned out. These all important relationships among the members of the team mirror and support the growing emphasis of the SEED model on respecting, understanding, and working within the complexities of the many simultaneously occurring and interrelated relationships — relationships between children and their biological and foster parents; between biological families and foster families, and between child welfare workers and the clients that they serve.

Crystal has been adopted. She is a thriving, happy child who is about to turn 6. She is doing well in her kindergarten class. She is deeply loved by her adoptive parents who describe her as the "missing piece in the puzzle" of their lives. She has a loving extended family that includes members of her biological family. Her biological mother came forward just before the termination of parental rights hearing. She thoughtfully relinquished her rights and attended the hearing so there would be no question of her intentions. She gave her blessings to the adoptive family and expressed gratitude. Crystal continues in weekly psychotherapy with the SEED psychologist and her parents have frequent collateral contacts. Crystal still struggles with deep fears and feelings of loss and anxiety. She is far more likely, however, to use words, play and proximity seeking than she is to have tantrums or fall apart over any small transition. Her mother remarked recently that comparing photos from when they first met to now, she saw Crystal's scared and sad reserve giving way to the kind of self-assured pose that one would hope to see in a child her age.

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THE ACCIDENTAL ADVOCATE:

Moving From Individual Case Advocacy to Systems Change

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Infants and toddlers who are involved with the child welfare system present clinicians with complex problems that are often compounded by systemic barriers to getting the help they need. Professionals who provide clinical services to infants, toddlers, and their families routinely engage in individual case advocacy to ensure that children and their families receive needed developmental, health care, and social services. Most clinicians would agree that individual case advocacy is part of the role of "helping professional." But moving from individual case advocacy to promoting systems change usually seems like a new – and often daunting — role for clinicians whose choice of profession and training have focused on work with individuals. However, when our efforts to improve the outcomes for high-risk infants are thwarted repeatedly by uninformed public policy, regulations, and practice, clinicians feel compelled to address these systemic problems. We become "accidental" advocates as we realize that if we do not actively address systemic problems, we are likely to prolong an unacceptable status quo, undermine the positive impact of our work with individual families, and contribute to our own sense of professional "learned helplessness" and even burnout.

Moving from individual case advocacy through accidental advocacy to active, planful, and productive collaboration with a broad-based coalition to promote systems change is a developmental process. This article describes how a hospital-based interdisciplinary team began this journey – initially, as a response to our frustrations in serving infants and toddlers – and tracks our efforts toward collaborative systems change.

Building "Starting Young"

In the early 1990s, our hospital-based pediatric interdisciplinary neurodevelopmental team received a large number of referrals from foster care agencies. Typically, 4- and 5-year old children would come to us with apparent behavior problems. We found that most of these children had developmental delays, and we referred them to the developmental

This work was made possible by a grant from the Administration on Children, Youth, and Families, Children's Bureau, U. S. Department of Health and Human Services. The contents are solely the responsibility of the author and do not represent the official views or policies of the funding agency. Publication does not in any way constitute an endorsement by the Department of Health and Human Services.

services available to preschool children in the community. Many of the children had been exposed prenatally to cocaine and other teratogens. In almost every case, we learned that the child's foster mother had first noticed delays at the time the child entered placement as an infant or toddler. Yet these children's health care providers had not linked foster parents to early intervention screening services. The children's foster care workers were unaware of the extensive network of early intervention programs in the county and of the fact that children in foster care were entitled to screening. Furthermore, despite a mandate to conduct community outreach, early intervention programs were not contacting child welfare agencies in their efforts to identify babies with potential delays.

When the Pew Charitable Trusts' Fund for Health and Human Services in Philadelphia issued a request for proposals for services to disadvantaged children, the neurodevelopmental team saw an opportunity to craft a solution to the problems we were seeing. We called our proposed program "Starting Young." It was funded in 1992.

The Starting Young Program is an interdisciplinary developmental diagnostic and referral service that is designed exclusively for infants and toddlers who receive foster care, kinship care, family preservation, or in-home child welfare services from the Philadelphia Department of Human Services (DHS). Its aim is to link these children to early intervention services through Part C of the Individuals with Disabilities Education Act, and to ensure that they receive appropriate health care and social services. Based at The Children's Hospital of Philadelphia (CHOP), Starting Young evaluates approximately 10% of the more than 1,100 children under 31 months of age who are in foster care in Philadelphia County in any given year. We accept referrals directly from DHS caseworkers or from more than 40 agencies under contract with DHS. Originally funded by The Pew Charitable Trusts, the program is currently funded by a grant from the Children's Bureau of the U.S. Department of Health and Human Services.

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Starting Young's interdisciplinary infant-toddler assessment team includes a pediatrician, child psychologist, speech-language pathologist, and physical therapist. A pediatric social worker conducts intake interviews and facilitates referrals, while a research assistant maintains the information database. The team also includes an intake worker from ChildLink, Philadelphia County's early intervention service coordination agency. Her role is to explain the early intervention program to the child's caregiver, complete the county intake forms for eligible children, and facilitate timely and smooth admission to early intervention services.

at a glance

- This article describes how a hospital-based interdisciplinary team moved from "accidental advocacy" to planful collaboration to produce systems change.
- The Starting Young Program, an interdisciplinary diagnostic and referral service, also engages in individual case advocacy and community collaboration.
- Participation in the Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition has led to a 5-question approach to gathering key medical data on children entering substitute care, more extensive health policy recommendations, and intersystem consultation.

Children's foster and/or biological parents are present for the assessment, accompanied by the child welfare worker. The team presents evaluation results and recommendations to the child's caregivers and the child welfare worker. We may recommend further evaluations with medical specialists, as well as referrals for early intervention and social services. We also offer specific strategies that caregivers can use immediately to enhance the child's development – for example, positioning strategies for an infant or toddler with hypotonia, or behavioral management strategies for a toddler who is biting other children in the foster home.

Once we receive authorization to release information, we send reports to the child's social worker from the private child welfare agency, the DHS caseworker and the caregiver (foster parent and/or biological parent). In addition, we send the report to the child's attorney if we believe that additional advocacy in court is needed to ensure that the child welfare agencies will adhere to specific recommendations regarding the child's health and well-being (legal consent to release evaluation reports to the child's attorney is not required). Eight to 12 weeks after the evaluation, Starting Young's social worker follows up with the caregiver to make sure that the child is receiving recommended services. We reevaluate children every 6 months until they are 30 months old, regardless of foster care placement or discharge.

Starting Young also serves as a resource to professionals and caregivers of young children in foster care in the Philadelphia metropolitan area by working with a consortium of private, nonprofit child welfare agencies to publicize its service program and train child welfare professionals in both public and private agencies on children's health and

development. Our educational programs focus on communicating information about the importance of early child development and its impact on later outcomes, highlighting published research on the pediatric and developmental needs of foster children, and bringing it all home by presenting local data from the Starting Young database. Feedback from our colleagues over the years confirms the value of "objective, practical research" to community stakeholders (Barratt, 2001, p. 30). In turn, in the course of presenting educational programs to our child welfare colleagues, we learn about child welfare practice and policy issues, making these interactions mutually beneficial.

The Impact of Starting Young

How effective is Starting Young? We use our database to look at three aspects of our program's impact.

- ***Identifying health and developmental problems.*** We refer nearly half of the children we assess for early intervention services. We refer 4 out of 10 children we see to medical specialists for problems that their primary health care providers did not identify. We also identify a significant number of infants and toddlers who are under-immunized (Silver, DiLorenzo, et al., 1999).
- ***Individual case advocacy.*** Our team engages in advocacy on behalf of approximately one-third of the infants and toddlers we see (Silver & Zukoski, 1997). For example, during the Starting Young evaluation we may observe poor care by the child's current caregiver that we believe approaches the threshold for neglect. In this circumstance, we would discuss this concern with the worker during the evaluation session and, if the child welfare agency worker is not persuaded of the gravity of the situation, we would contact the agency supervisor or take additional action to convene a meeting to develop a solution to the problem that achieves consensus. Another example is the parent or foster parent who may need our assistance in overcoming barriers to getting needed services for the child. We also become involved when we believe that an administrative decision by the county child welfare authority regarding a specific child is harmful, and was determined without consideration of the child's emotional, developmental, and medical vulnerability. For example, in one case a toddler who had struggled with Traumatic Stress Syndrome, poor growth, and poor control of her asthma, had finally achieved stability in a new foster home. This stability was not easily achieved. It involved much sensitivity on the part of the foster parents and repeated visits with the health care provider. As a result, the toddler's symptoms of intense fear and anxiety had abated, she gained weight, and her asthma came under good control. Abruptly, the county child welfare agency wanted to move the child (with a week's notice) to another county largely for administrative reasons. The private foster care provider agency did not agree, but did not want to rock the boat with the public agency. In a case such as this, we may contact various stakeholders in the child's life to convene a meeting: the county office of children and youth, the private foster care provider agency, and the child's legal advocate. In the meeting we will discuss our concerns, provide information based on the child's comprehensive evaluation in our program, and offer recommendations based on our professional expertise to formulate a solution to the problem.
- ***Adherence to team recommendations.*** When we look at the degree to which the child's caregivers and child welfare workers follow the recommendations of the Starting Young team, we find mixed results. There is good follow-through on recommendations for early intervention services (83%) and for updating immunizations (76%). Yet although 60% of the babies we see have some kind of chronic medical condition (more than three times the expected rate for infants and toddlers [Newacheck, et al., 1998]), there is only moderate (57%) follow-through on recommendations for specialized medical evaluations (Silver, DiLorenzo, et al., 1999). Recently, the Starting Young Program was awarded funding from the Children's Bureau to investigate the reasons for the weaker adherence with the team's recommendations for medical specialty evaluations.

The Starting Young Program evaluates approximately 100 to 130 babies each year. Perhaps the most significant limitation is that the program sees only a small fraction of the 1,100 infants and toddlers under 31 months who are in foster care in Philadelphia, and the even larger number who remain with their parents receiving in-home child welfare services. The health and developmental needs of these vulnerable children may be unmet.

Moving from Individual Advocacy to Systems Change

Becoming a trustworthy partner in community collaboration. During the 8 years that the Starting Young Program functioned with support from The Pew Charitable Trusts, we learned about barriers that interfere with foster children's health, development, and well-being. Through dealing with referrals from over 40 child welfare agencies, dialogue with senior administrators and front-line workers from public and private child welfare agencies, discussions with hundreds of foster parents, and participation on several community-wide task forces, we learned about issues and diverse perspectives within the child welfare system. Most important, perhaps, we found colleagues who were as passionate as we were about improving outcomes for children and families involved with the child welfare system, and equally frustrat-

ed by systemic barriers. We found allies to work with in crafting more far-reaching solutions.

An invitation to Dr. Trude Haecker, the Starting Young team pediatrician and director of ambulatory pediatrics at our hospital, to attend a meeting concerning the newly funded Family to Family Foster Care Reform Initiative gave us our first opportunity to work collaboratively with a community-wide task force. The initiative, funded by the Annie E. Casey Foundation, was designed to decrease the number of children placed in foster care, the length of time in placement, and the number of disrupted placements (Silver, DiLorenzo, et al., 1999). Jointly hosted by the Pennsylvania Department of Public Welfare and the Philadelphia Department of Human Services, the meeting brought together representatives from City Council and a state legislator's office, legal advocates, members of a local interfaith action alliance, as well as administrators from numerous child welfare agencies, and foster parents. This group became an ongoing ad hoc advisory group and we participated regularly, always bringing up the issues of health care and early intervention to the larger group, volunteering for committee work, and providing information about Starting Young at every opportunity. The relationships we formed greatly enhanced our effectiveness in individual case advocacy. We could now bring problems we identified to the attention of colleagues with supervisory authority rather than lodging formal complaints. This relationship-based approach to problem solving was more palatable and far more productive than "righteous indignation" directed at front-line child welfare staff.

The passion of pediatric residents. When Dr. Haecker moved to CHOP, she encountered a group of pediatric resident physicians who were frustrated by the "confusion and chaos" associated with providing health care to children in foster care (Silver, Haecker, & Forkey, 1999, p. 184). They sought to determine whether the problems they encountered were due to their relative inexperience with the child welfare system as pediatricians-in-training, or whether these problems were generic to all children in substitute care. The residents organized themselves as an advocacy group, asked Dr. Haecker to advise them, and identified three issues to address:

- Lack of medical records for children in foster care and/or relevant information from the child welfare agency;
- The parameters of confidentiality (Who should have access to medical information?); and
- The parameters of legal consent for pediatric care.

Not surprisingly, perhaps, the residents had identified three systemic issues that were central to improving health and developmental outcomes for children in foster care but were not easily resolved. When they met with child welfare leaders and health and legal experts to whom Dr. Haecker introduced them, the residents got differing responses to their questions. The residents then convened a series of meetings, open to everyone interested in improving the health care of children in substitute care, that attracted representatives from state and city health and human services agencies, practitioners and administrators from private foster care agencies, hospital-based health care professionals, and attorneys working in institutions and children's advocacy programs. This multisector group has met monthly since 1996, eventually joining the Pennsylvania Children's Health Coalition as its Subcommittee on Children in Substitute Care. (See Silver, Haecker, et al., 1999 for a description of the early development of the group.)

The Subcommittee on Children in Substitute Care. Current and former members of the Starting Young Program have been active participants in the Subcommittee and the Pennsylvania Children's Health Coalition as a whole. We have moved from individual case advocacy to trying to improve the responses of the systems that affect the lives of children in substitute care (Culbertson, 1991, citing Melton, 1983). Following Knitzer's formulation of systems-oriented advocacy as concerned with basic rights that are enforceable by statutory, administrative, or judicial procedures (Knitzer, 1976, as cited in Culbertson, 1991), the Subcommittee decided to focus its attention on children living in substitute care and their basic right to healthy development

Health care professionals' clinical experiences, reports from private foster care providers, and data from the Starting Young Program told us that children in foster care were not receiving the routine preventive health care, specialized health care services, or early intervention services needed to ensure their healthy development. Children did not receive these services despite their legal entitlement to federally mandated Early Periodic Screening and Diagnostic and Treatment (EPSDT) and early intervention services. The health care children received was not congruent with the standards for health care for children in out-of-home care issued jointly by the Child Welfare League of America and the American Academy of Pediatrics (CWLA, 1988). As a result, children in substitute care in our community were suffering from under-identified medical conditions, experiencing preventable medical crises, missing out on needed medical and developmental interventions, and suffering from secondary disorders that arose when their primary conditions were not sufficiently treated.

Sheryl Dicker's research on successful children's advocacy campaigns (1990) points out that campaigns that have made a genuine positive difference in children's lives share three characteristics. Successful advocates:

- propose concrete solutions to the problems they address;
- use a variety of strategies over a prolonged period; and
- forge partnerships within governmental bodies to facilitate implementation of the reforms (Dicker, 1990).

Dicker also observes that successful advocacy requires fact-finding, assessment of the political situation, and personally flexible advocates (Dicker, 1990).

Using five questions for systems change. The

Subcommittee on Children in Substitute Care focused its efforts on the three specific concerns originally identified by the pediatric resident physicians. As members of the Subcommittee located their agencies' guidelines and regulations and reported them to the group, the Subcommittee realized that key health information about children was not being collected at the time of removal from their parents' care. We also learned that medical information that did exist in DHS records was not maintained in a specific section of the family's file; thus, a caseworker would have difficulty finding and monitoring a child's health status, let alone providing information to a health care professional during a medical emergency. Finally, we discovered that many of the restrictions on sharing medical information from a child's DHS file with health care professionals and foster parents were not based on legal requirements, but rather on misinformation that reflected pervasive misunderstanding of the parameters of legal confidentiality.

Armed with our facts, and relying on partnerships among members inside and outside of governmental agencies, the Subcommittee crafted a simple approach to gathering key medical data on children entering substitute care. The health care professionals on the Subcommittee drafted five questions (see Table 1), the answers to which would provide essential information

DHS then integrated these questions on a form, the Children's Medical Insurance Information Form (CMIIF). The DHS worker would complete the form when a child entered placement. The information would then be included on the CMIIF Verification Report Form, which was sent to the child's foster care agency and filed in the family's DHS case file. In other words, crucial health information about a child could now be communicated to the children's foster parents and health care providers. In addition, Subcommittee attorneys provided guidelines regarding confidentiality and consent issues; these were circulated among all Children, Youth, and Family Council agencies and local academic health care centers.

TABLE 1
FIVE QUESTIONS TO ASK ABOUT CHILDREN ENTERING SUBSTITUTE CARE

1. Did the child's mother have any health issues during pregnancy (e.g., substance abuse, infection, premature labor or delivery)?
2. Has the child ever been hospitalized (e.g., due to medical problems, accidents or surgeries)?
3. Does the child have any medical diagnoses (i.e., special health care needs for pediatric specialty care) or is the child prescribed any medications?
4. Does the child have any allergies?
5. Are there any medical problems that run in the family (e.g., asthma, sickle cell anemia, seizures, etc.)?

Monitoring implementation. Several months after the initiation of these measures, the Subcommittee inquired how the implementation was proceeding. To our disappointment, we learned from our colleagues at DHS that many of the CMIIF forms were arriving in their office with the five questions unanswered. This discovery highlights the importance of monitoring the implementation of "reforms" (Dicker, 1990). The Subcommittee then shifted strategies. We realized that many children who enter foster care previously received in-home services designed to prevent placement. We asked for help from the private child welfare agencies that provide in-home services to families involved with DHS, suggesting that the five questions could be posed by in-home child welfare workers, whose role was clearly less adversarial than of a DHS worker in the process of removing a child from the parents' care. The in-home worker could document the information obtained from parents in response to the five questions, so that if the child later required foster care, the information was available. As a result, in July 2001, when DHS published new standards for agencies providing in-home child welfare services, it specified that agencies were required to ask the five questions when conducting the families' safety needs assessment. Although this specification by DHS may be considered a partial victory, the agencies' adherence to this requirement remains unknown and will need to be monitored.

Health Policy Recommendations for Children in Substitute Care in Philadelphia. The initial success with the Five Questions, though modest, encouraged the Subcommittee to continue meeting, raising issues for joint consideration, and crafting solutions. In 1999, the Subcommittee published a document, *Health Policy Recommendations for Children in Substitute Care in Philadelphia* (available on the Web site of the Juvenile Law Center, www.jlc.org). This document identified three areas where change was needed to improve children's health and developmental and mental/behavioral health outcomes:

1) state law, regulations, and policy;
2) policy and practice in the child welfare system; and
3) juvenile court procedures.

The document identified specific issues and proposed specific recommendations for concrete solutions (Dicker, 1990). Recommendations for state regulations and policy included the modification of state child welfare regulations to require county children and youth agencies to refer all children under 5 years old who are entering substitute care to be referred for early intervention services and Head Start services. Recommendations for child welfare professionals encouraged them to obtain parental consent to provide early intervention service.

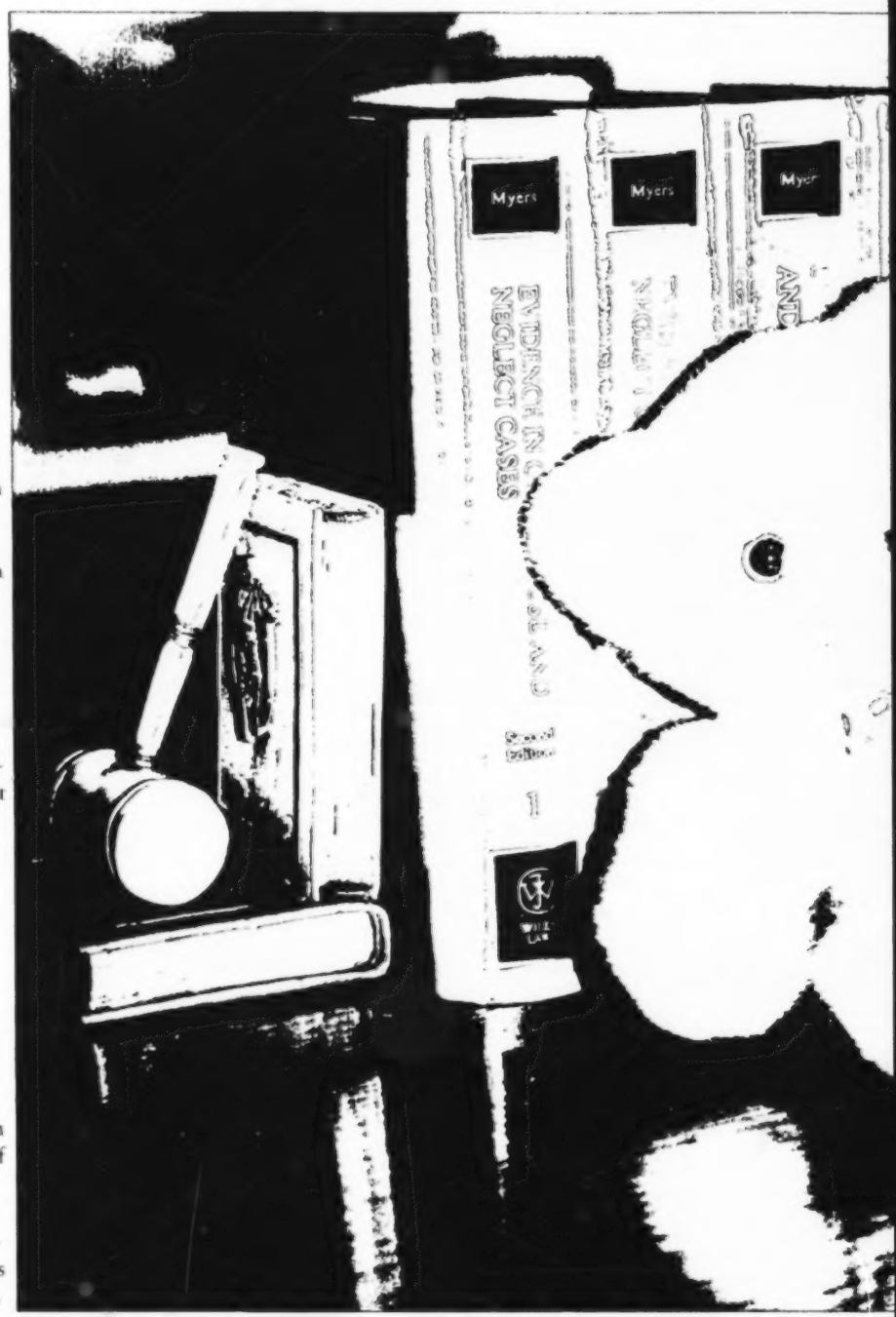
We distributed the *Health Policy Recommendations* widely — to state and local leaders in public child welfare agencies; state legislators; the county commissioners of health and

human services; city solicitors; directors of private child welfare agencies, early intervention programs, and children's advocacy agencies; legal advocates; and health care professionals. In one-on-one meetings and presentations for regional leaders, we campaigned for endorsement of the *Health Policy Recommendations* from this broad range of professionals. The Chief Administrative Judge of Family Court became one of our first supporters, sanctioning the implementation of the document's recommendations in Family Court proceedings.

After the publication of the Health Policy Recommendations, the Subcommittee focused more intensely on improving the access of children in substitute care to early intervention services, including quality mental/behavioral health services. In addition to raising awareness throughout the professional community about the heightened need of children in foster care for medical and early intervention services, the Subcommittee has had significant specific successes:

- Philadelphia County has pilot tested a computerized medical passport to improve the gathering, maintenance, and availability of up-to-date medical information on children in substitute care.
- Private foster care providers have agreed to use a standard form for medical encounters and for discharges from foster care, thus easing the paperwork load on local physicians.
- The Subcommittee provided a forum for administrators both from DHS and from the county office of Early Intervention Services to agree to meet collaboratively and devise strategies to promote continuity of early intervention services when children change placements The Subcommittee joined legal advocates in successful protest against proposed changes in state early intervention regulations that would have prevented foster parents from becoming the "educational surrogate parent" for a child in foster care.

Perhaps the most far-reaching implementation of the *Health Policy Recommendations* has occurred recently in Family Court. As part of our local Model Court Improvement Program, all children who are being considered for placement in foster care are given a pre-hearing mediation that includes the parent(s) and their attorney, a city solicitor, and a neutral mediator. The Administrative Judge of Family Court has ruled that the five questions will



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be asked during this session, and that parents will be encouraged to sign consent forms to release their children's medical, early intervention, and/or mental health records to DHS to ensure continuity of care should placement occur. Parents are also encouraged to consent to the release of information about their children related to HIV/AIDS. Further, parents are asked to consider signing consent forms authorizing medical care, early intervention evaluations (and, when warranted, services), and mental health evaluations (and, if warranted, services). A brochure entitled *Healthy Children: How to Make Sure that Your Children's Health Care Needs Are Met While They are in Placement* was written for parents by Lourdes Rosado, Esq. (n.d.), of the Juvenile Law Center (as part of her work with the Subcommittee on Children in Substitute Care) and is available both in the waiting area and in the mediation room. It discusses the need for the consent documents, their importance in helping the children receive the services they need in a timely manner, and their contribution to good health and developmental outcomes.

The most far-reaching impact of the Subcommittee on the child welfare system as a whole may be the intersystem consultation that now occurs as a result of the relationships among different agencies and stakeholders that the Subcommittee has engendered. When someone has a question, he or she has trusted colleagues to go to for feedback and assistance. For example, when the Philadelphia Departments of Human Services and Public Health developed a computerized health passport system, they sought feedback on content from members of the Subcommittee. When two health care professionals conducted focus groups of foster parents regarding their perceptions of barriers to health care, members of the Subcommittee in both the public and private sectors helped recruit foster parents for the project. Recently, the county early intervention office and DHS examined their respective databases to see how many children in foster care were receiving early intervention services. When they learned that there was only a 14% overlap, they began to develop programming to ensure that all infants and toddlers entering foster care will receive a developmental screening. Their motivation to collaborate was due in part to the publication of the Health Policy Recommendations, data from the Starting Young Program, and the collegial relationships developed in the Subcommittee.

From Accidental Advocates to Agents of Change

Confusion and chaos are words that all too often describe not only the lives of children involved in the child welfare system but also the experience of professionals who are struggling to protect the rights of these children to healthy development. Children's complex problems are often compounded by systemic barriers to potential solutions. As this article describes the work of the Subcommittee, it is clear that not all of our efforts are immediately successful; we may take two steps forward and one step back. Dicker's study of successful advocacy noted that this pattern is typical and that children's advocates have to be involved for the long haul to realize positive results (Dicker, 1990). Despite some of the setbacks the Subcommittee has encountered, we have learned that it is possible for clinicians to move from being accidental advocates to agents of meaningful systemic change. By developing collaborations across agencies and systems, we can improve communication and coordination of services. We can begin to craft concrete solutions to specific systemic problems, and remain actively involved in implementation. We can make a difference.

Acknowledgements: The author gratefully acknowledges Margaret Zukoski, MSW, MLSP, of the Pennslyvania Council of Children, Youth and Families for the title, "The Accidental Advocate," based on her presentation at the 1996 ZERO TO THREE National Training Institute. Also acknowledged are the following colleagues for their careful reading of the manuscript: Heather Forkey, M.D., Children's Hospital of Philadelphia; Lourdes Rosado, Esq., Juvenile Law Center; Nancy Tomaszewski, RN, Philadelphia Department of Human Services. The writing of this article was supported by Grant DHHS 90CA1697/01 to the author.

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PLAY AND LEARN AT OUR PLACE

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PHOTO: ZERO TO THREE

His borrowed, evanescent smile didn't quite reach across the room as he moved away from his foster mother and in towards the toys. It was the train track that excited interest — the colorful array of tunnels and bridges, red plastic engines attached to blue and green wagon cars.

Simon stood watching two other boys take apart and reconstruct the pieces of track. He followed the movements their quick hands created as the train was made to go one way and another. The boys paid him no attention despite the intensity of Simon's observing eyes and rigid body. Then swiftly, like the flash of a razor-knife out of pocket, Simon kicked the train track, sending the pieces flying into terrible wreckage. Simon laughed a haughty, menacing laugh, and the other boys met his challenge with the violent faces, swinging arms, and strong legs that all of these 4-year-old boys had experienced many times before in their transient young lives.

Simon is a youngster who, at just under 4 years of age, has been in 12 foster placements intermittent to frequent trials of home life with his mother, who abuses drugs. In her own struggle to be loved and to survive, Simon's mother has lived with a series of partners, many of whom are criminal offenders, several of whom have physically abused her, and two of whom have sexually abused Simon. Simon has an older brother and a younger sister. Both siblings are in foster care, but none of the three children is in the same home.

I watched the boys, moving like boxers in a ring, and thought of the disaster and chaos, the disruption and fear that their actions reflect about their own early experiences. Can Our Place offer something to these little ones and to the other 250+ children who come to the Centre? How can we help to provide their foster and adoptive parents with the support, understanding, and stamina that they will need to parent these vulnerable children who are at high risk for emotional, educational, and placement breakdown?

Our Place is a center for families who foster and adopt children. It is a nonprofit, registered charity situated near the center of the city in Bristol, England, a city of 800,000 people in which there are approximately 550 children in foster care. About 35 of these children are adopted each year.

Our Place opened in September 1998, to address the

need for support, understanding, experienced knowledge, and professional input for families who foster and adopt children, and to help in the prevention of placement disruptions. The Centre is open 5 days a week from 10:00 a.m. until 6:00 p.m. There are some evening workshops and periodic Saturday activities. Because the Centre is privately funded, there is no cost for families or professionals coming to Our Place. The Centre is professionally staffed by psychologists, social workers, an occupational therapist with a counseling background, an educational specialist, and various art, music, drama, and dance therapists.

Foster and adoptive families come to the Centre to explore common interests and concerns, and to join in a large variety of activities and workshops for foster and adoptive parents and professionals. Children can attend music, art, drama, dance, cookery, social relationship, and friendship activities. Some children come for individual educational tutoring or emotional support sessions.

Foster and adoptive parents, social workers, health professionals, psychologists, and educators are invited to attend various workshops that consider the special needs of adopted children and children in care. Workshops about "contact visits" with parents and about sexualized and traumatized children have been much in demand, as has been information about the understanding and management of children with attention deficit hyperactivity disorder (ADHD). Other workshops include concerns about infant mental health, developmental vulnerability, the education and behavior management of children in foster care, and parenting unconventional children.

Our Place has been open for 4 years. During that time, over 400 families and professionals have attended various activities. The vast majority of the families who use the Centre are two-parent families with adoptive parents who are white, and more than one child in their house. However, many families have birth children, adopted children, and sometimes foster children in their households, and an increasing number of families who adopt from overseas have been coming to the Centre. Recently, we have also seen an increase in the number of foster families who come to Our Place.

Although there are no age boundaries for children coming to the Centre, most of those who come frequently are between the ages of 3 and 14 years. In the United Kingdom, the average age of a first-time adopted child is 6 years (Gilles, 1999), and this child has had an average of eight moves prior to the first adoptive family placement. Moreover, an estimated 20% of all adoption placements "disrupt" (Gilles, 1999; personal communication, 1999). In the author's professional experience, and according to numerous research studies, (Bretherton, 1980; Fahlberg, 1994; Lowe et al., 1999; Parker, 1999), many disruptions occur as a result of little or no support for the adoptive and fostering families,

at a glance

- Our Place is a center specifically designed for families who foster and adopt children.
- The "Play & Learn" group for foster children up to4 years old addresses children's particular developmental and emotional needs.
- Formal and informal contact with foster and adoptive parents, as well as workshops, support parenting skills and prevent placement breakdown.

and because foster and adoptive parents do not have the knowledge and training they need and want in order to care for the children who come to them with very damaged lives. Many adoptive and foster parents at Our Place have expressed sorrow and resentment that they did not have a facility such as Our Place available to them when their children were younger – saying that given this experience and knowledge, they might have understood and cared for their children more effectively.

In this context, Our Place's "Play & Learn" group for foster and adopted children 4 years old and under and their foster and adoptive parents serves a critical dual purpose. First, the specially designed and professionally staffed group experience encourages healthy development among children who are already showing or are at high risk for significant developmental problems (Richardson, West, Day & Stuart, 1989; Silver, 1999; Spiker & Silver, 1999). Second, Our Place's services for children and support for foster and adoptive parents are designed to prevent placement breakdown – increasing the odds that vulnerable children and their foster and adoptive parents will be able to build solid, stable relationships.

Melissa is typical of the infants who come with their foster parents to Our Place. At 15 months, she is just beginning to pull herself to standing. She makes some sounds and noises, but no recognizable words. Melissa is very reluctant to make eye contact; however, she goes to adults randomly and openly, reaching her arms out to be picked up. Nevertheless, she doesn't enjoy being held, so usually wants to be put down again once the adult has responded to her outreach.

Melissa is the second youngest of four siblings, the oldest being 5 years. The two older girls are in placement together; Melissa is with another family, and the infant is with yet a different foster family. There is some attempt to have the children see one another, and for all of them to spend contact time with their mother and grandmother. An adoption order is not in place for any of the children,

although the social workers say that it is highly unlikely that they will return home. Informally, an adoptive placement is being sought for Melissa, but as she is not freed for adoption, this is a complicated issue. Currently, Melissa enjoys her foster family, which includes a 14-year-old adopted child. Melissa is an active child who could benefit from learning how to explore and enjoy a toy, how to make reciprocal eye contact with another child or adult in her circle of play, and how to attend to a picture book, song, or conversation for even a short period of time. These are all issues that are being addressed in the Play & Learn group.

The Play & Learn Group

Like all children's activities at Our Place, Play & Learn requires a very high child to staff ratio. Usually, we have three staff for the six to nine children between the ages of 9 months and 3 years who attend each week. From the time we first began this group, as a professional staff, we were startled that none of the children was functioning at what we would have considered to be a developmentally appropriate age level. Not surprisingly then, it was impossible for us to do any of the activities that we would have anticipated carrying out with nursery-age children. For example, at the beginning of this group, none of the children (1 to 3 years of age) was speaking with more than two words at a time, and only three of the children spoke any words at all. Neither of the children who were 1 year old could stand on his or her own, although one did pull to standing while holding onto furniture. Both of these children were physically very small, (typical of children in foster care, who are often born at low birth weight), as was one of the 2-year-olds. A boy of 9 months was not yet sitting, but was just beginning to crawl. None of the children showed any interest in listening to even a brief story, nor could they sit long enough to engage in looking at picture books. A couple of the older children were able to make some marks with a crayon on paper, but they showed little interest in doing so.

The focus in Play & Learn, from the staff's point of view, is to understand and meet the child at whatever developmental level is being manifested.

Attention span for all of the children was markedly low, as were fine motor skills. Two of the children seemed to have normally developed gross motor skills, but the other four all had some degree of delay or awkwardness.

At 3 years, Joel is the oldest child in this group. Joel's adoptive parents are waiting for a court date and his final adoption papers. He came to these parents when he was 13 months of age, after a traumatic beginning with a substance abusing mother and an unknown father. When he was 7 months old, his young mother – alone, scared, abused, and exhausted – tried to quiet Joel by suffocating him with a wash cloth. Although kinship care was given a trial with both the maternal grandmother and an aunt, neither of them provided Joel with sufficient nurturance and sustenance to enable him to stay in these homes.

Joel is an ebullient, well-meaning little boy who is clumsy, internally unregulated, slow-of-speech, and generally unable to recognize or communicate most of his needs or desires. He is frustrated by his inability to get his messages adequately conveyed, even to those who know and love him. In his efforts to make friends, he overwhelms his playmates and requires constant adult supervision when with other children.

In an effort to address some of the complicated needs of the children in our Play & Learn group, we use an occupational therapist (OT) and a speech therapist as periodic consultants. The OT comes every other week and the speech therapist once every 2 months. In addition, a part-time music therapist works with both the children and the foster and adoptive parents on a fairly regular basis. With slow but steady progress, we persist in reading stories to the children, and we continuously involve them in various art and cooking activities, encourage their gross and fine motor skills through play, and spend a lot of time following, mirroring, encouraging, and expanding their own play.

Michelle first came to us at 13 months. She is the youngest of four children in her foster home, although she is the only fostered child there. The social workers, attorneys, and families cannot come to agreement about the possibility of Michelle's returning home as her mother has mental health difficulties that are not resolved. At times, the grandparents have made efforts to care for Michelle, but the demands of a small baby are too much for them. Michelle was crawling when she arrived at Our Place. She had no words and very few sounds. Eye contact is extremely difficult to establish with her. Michelle eats anything that is put in front of her, including most of the art materials; yet she mouths toys and objects, and experiments with touch in a very limited fashion.

The focus in Play & Learn, from the staff's point of view, is to understand and meet the child at whatever developmental level is being manifested. As with all children, this is never a flat line, but one that fluctuates depending upon the child's varied abilities and interests, mood of the day, individual skills, need to communicate or not, and the composi-

tion of the group of children who have come on any given morning. There is a tremendous amount of one-to-one attention and enormous planning about how to meet the individual needs of each of these children, all of whom exhibit some out-of-the-norm behaviors.

In the Play & Learn group, it is persistently obvious that not only the level of development, but also the quality of development and play is somewhat different for children who have been jeopardized,(usually neglected and/or physically, including sexually, abused), in their early environment. Our highly trained professional staff must stay attuned to the particular developmental and emotional needs of children who are or have been in foster care. For example, eating, including hoarding and stealing, is a constant issue for all children at Our Place — as it is for most adopted and fostered children in general — in the sense that neglect is a frequent reason for taking a child out of the home, and neglect usually means inadequate and inconsistent feeding. Studies of adopted and fostered children consistently report a high propensity of eating difficulties, hoarding, stealing, and lying about food (Fahlberg, 1994; Keck & Kupecky, 1995; Archer, 1999).

Going to bed, a much-repeated theme in the children's play, can have special meaning for children in our Play & Learn group. Many young children in foster care have had early experiences of being left unattended in cribs, beds, or infant seats for long periods of time. This has had a deleterious effect physically, emotionally, and developmentally for them. Being left alone and confined for a long time inhibits one's ability to explore and experience one's environment, and the feelings of neglect can have a powerful impact on the child. Even at the ages of 3 and 4 years, a significant number of children have been sexually abused during bath times or at bedtime. Scenarios that foster and adoptive parents describe around difficulties with bathing and with getting children to sleep at night reinforce the traumas these children have experienced and that influence their daily lives and those of their caregivers.

Most of the infants and toddlers in the Play & Learn group – indeed most of the children coming to Our Place – have experienced emotional, physical, and sexual abuse, so their expectation of adult contact is often quite different from that of a child coming from even a "good-enough" home. Affection is either unknown or unpredictable, and sometimes inappropriate. Communication has frequently been in the form of yelling and anger rather than of an interactive, reciprocal exchange. Slamming doors, loud voices, particular smells or noises, and other unexpected stimuli can evoke unusual responses from children in foster care that their caregivers usually have no way of anticipating.

Providing Support for Foster and Adoptive Parents

At Our Place, one foster or adoptive parent is required to stay in the building while the child is participating in an activity. This means that the parent is there and available to chat with our staff and with consultants who come to the Centre. Foster and adoptive parents who participate in Play & Learn join in the activities for some of the morning, and then sit in an adjoining room for coffee, discussion, and relaxation. A staff member is always available to chat with parents if they have questions or if they just want to talk about something that has been going on at home. Both foster and adoptive fathers and mothers of these children have clearly benefited from the particular insights of the staff about their children and from their own relaxed and informal conversations. At times, however, depending upon the perceived mood of the morning, the parents may chat without a staff member present. We try to be available and attentive, but not hovering or intrusive. As there is an open doorway between the playroom and the coffee room, children and parents can always be available to one another. Sometimes, the door is shut so that parents can talk with greater privacy and confidentiality.

The staff makes considerable effort to find the balance between engaging foster and adoptive parents in play with their children, modeling appropriate interactions and behaviors of play, chatting about what the children are doing/saying, and allowing the parents to have some time away from their little ones, as all of these parents have emotionally and physically exhausting lives.

All the foster and adoptive parents who come to Our Place, including those of the Play & Learn group, have been extremely receptive to attending workshops about early child development and attachment. They tell us that understanding the prenatal and perinatal periods of infancy, in addition to the child's first few years of life, has changed the way they have come to appreciate and deal with all of their children. Besides looking at normal development in these workshops, we have discussed the ramifications for infants and young children when things go wrong in their first few months/years of life. We discuss risk, vulnerability and the delays that can accompany children who have been exposed to drugs prenatally, who have experienced early trauma, and who have been removed from dysfunctional family environments. This is not information that our foster and adoptive parents feel they have had explained to them previously. Parents frequently comment that social workers and teachers ought to be attending these sessions as well. Although they are invited, few come.

Signs of Progress

The children and their foster and adoptive parents have now been at Our Place long enough for us to see progress in all of them. One of the youngest children has recently left, as he has been moved to an adoptive home. This child, 14 months old when he left, and the least capable of those in the group, was just beginning to pull to standing and to make some sounds other than crying and other fussing noises. Melissa (described above) is now walking on her own and is definitely attempting imitative

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and meaningful word sounds, although no real words have yet emerged. Another 26-month-old child, adopted from overseas and exposed to a different language in her first year of life, is now speaking many words and is putting together a few two- and three-word phrases. Her speech is clear and appropriate, and there is no indication that her speech will be problematic once she makes sense of the English language. The older children have made considerable progress in their language development, although Joel's skills (described above) are still significantly below what would be expected of a child his age. His speech is clearer, but his language and communication skills remain awkward and delayed.

The children's social skills have improved enormously. This is particularly noticeable as they eagerly wait to greet each other as they arrive in the morning. The older ones know everyone's name and can call one another by name. They all look forward to singing our beginning song of "Hello, (name of child)." Sharing is not yet a concept available to the members of this group, but they do enjoy parallel play, and they like to have their new friends around them. Perhaps it is because the children have been working particularly hard on their communication skills, so that they can interact with one another, that their fine motor skills still lag far behind. They show some increased attention to both books and manipulative arts and crafts projects. Yet the quality of their fine motor movements does not seem to have progressed as much as their language has. Even holding utensils for eating is a task that still presents difficulties.

Like their children, foster and adoptive parents clearly enjoy social interactions at Our Place, and they frequently attend other workshops and activities at the Centre. They are quick to say that they have learned a lot about early childhood development at Our Place and that they try out at home the ideas and suggestions presented in workshops and by the various therapists who come to Play & Learn. Since all but one of these parents have older children, they frequently comment on how useful the sessions on various aspects of development and on adoption issues in general have been to them and to the rest of their family.

Parents have been very enthusiastic about wanting to continue the Play & Learn group, contrasting it with other toddler groups they have attended where there are far too many children and no specific guidance or direction in managing behaviors or developmental difficulties. In other toddler groups, there are rarely other foster or adoptive parents who can understand and support the particular needs of these children and families, who learn and live unconventionally.

Early intervention in the context of the Play & Learn group has had good results. Neither progress nor social interactions can be absolutely quantifiable, and it is never possible to be sure that a particular skill was learned or improved as a result of the intervention, but there is little doubt that all of the Play & Learn children have made larger leaps than their developmental course would have suggested prior to their coming into this group. Moreover, they have had opportunities to interact socially in a small, well-monitored setting, which has brought pleasure and incentive to become involved.

We want and need to persist in our conviction that early intervention for children and their foster or adoptive parents, coupled with a nonjudgmental approach to supporting the parenting skills of adoptive and foster parents, is a promising approach to fostering positive developmental growth and the prevention of placement breakdown for children in the foster care system. Early intervention for the children and increased understanding of child development for their foster and adoptive parents enable the young children in foster care to have more stable and supported beginnings, and therefore, firmer, more solid foundations on which to grow and develop.

Finally, it must be said that none of this has come smoothly or without extensive staff discussion about the best way forward. For example, our work is always tricky when there is a foster or adoptive parent who persists with disciplinary actions that we find troublesome. It is never easy to look at the backgrounds of these children and to try to ameliorate the horror, the sense of separation and loss, and the instability that they have experienced. Often, the children are either too willing to cuddle and placate or they are too distant and aloof to provide the positive feedback the adults' efforts merit. Fortunately, our staff team is extremely compatible, open-minded, and flexible. We work unusually well together, and, at the end of the day, it may be this atmosphere of geniality and supportiveness that enables us to provide the most enriching and enhancing care to children and foster and adoptive parents at Our Place.

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Intervening With Young Children in Foster Care:

Using Countertransference Reactions to Facilitate the Therapeutic Process

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Photo: Marilyn Nolt

Young children in foster care have a profound need for safety and security (Goldstein, Freud, & Solnit, 1973). They have often experienced prior neglect, abuse, or abandonment, are undergoing a major separation from their parent(s), and live in an ongoing state of uncertainty about their futures. A safe and secure therapeutic relationship can provide the necessary context in which to begin to address the deep sense of uprootedness that these children are experiencing, their lack of trust in others, and the often pervasive belief that they are unworthy of love (Bowlby, 1988). Despite its importance, developing a safe, secure therapeutic relationship with children in foster care is often highly challenging. Many children in foster care elicit strong feelings in therapists who treat them. When this happens, a therapist's countertransference feelings can threaten to disrupt therapeutic progress.

In this paper, we describe two types of countertransference reactions that we have experienced while working with young children in foster care. We argue that countertransference reactions can threaten to disrupt therapeutic progress because a therapist may find him or herself unwittingly confirming a child's expectations of the self and others. If recognized, shared, and understood, however, countertransference reactions can be a powerful vehicle both for understanding a young child's feelings about the self and others and for establishing a more genuine and realistic therapeutic relationship with the child and his or her caregivers. We accord reflective supervision and team meetings a vital role in this process. Supervision can provide therapists with a safe haven for sharing feelings, for gaining perspective, and for increasing their ability to respond.

The Parenting Assessment Team

Our work with children in foster care began in1995 in the wake of a highly publicized case in Illinois involving a mother with schizophrenia, who killed her young son shortly after he was returned to her care. A mental health task force subsequently recommended the creation of an independent assessment team to aid the Illinois Department of Children and Family Services and the Cook County Juvenile Court in decision making. The Parenting Assessment Team at the University of Illinois at Chicago provides comprehensive evaluations of the parenting capabilities of individuals with major mental illness whose children have been removed from their care (Jacobsen, Miller, & Kirkwood, 1997).

In 1998, our team took on the challenging task of offering treatment to mothers with chronic mental illness and their children. We have found that a comprehensive and coordinated approach to treatment is necessary to address the multiple needs of mentally ill mothers and their children. Social workers, psychologists, and psychiatrists thus work together to assess parenting strengths and weaknesses and to plan appropriate treatment. Treatment often includes a combination of dyadic psychotherapy, individual therapy for mothers, play or individual psychotherapy for the child, psychiatric monitoring and medication management, participation in a parents' support group, as well as collaboration with caseworkers and the court system. We meet weekly as a team to discuss our cases and provide reflective supervision for interns and junior staff.

Mothers who are seen by our team have been diagnosed with schizophrenia, schizoaffective disorder, bipolar mood disorder, post-traumatic stress disorder, recurrent major depression, or with personality disorders. Many also have substance use problems. All have young children between the ages of birth and 5 years.

A central part of our approach to therapy is to enhance a mother's caregiving skills, to promote empathy for the child's developmental needs and affective experiences, and to facilitate the development of a positive mother-child bond by providing the mother and child with a secure therapeutic base. We work with the child's biological mother if it is likely that she will regain custody of her child. However, in cases where a mother's rights are being terminated, we strive to work with the most viable parental figure(s) so that this person can function as a secure base for the child. In the two cases we describe in this paper, different circumstances prevented us from seeing either their biological or foster mother with the child in dyadic therapy. During the initial phases of therapy, the children were thus seen individually.

John Bowlby, a pioneer in the area of parent-child attachment relations, stressed that a child's expectations of the self and others and his or her resulting ways of communicating emotionally with others, are built up during infancy and toddlerhood (1988). By early childhood, these expectations become established as influential cognitive structures. An underlying assumption of our individual therapeutic work with the two young children was that the experience of a corrective therapeutic relationship, generated through a safe, supportive, and empathic stance, would help to revise the children's lack of belief in the availability of others and the negative feelings they had about themselves.

Children We Wanted to Save

Young children who are open, needy, and affectionate often have a profound impact on members of our team. Therapists on our team sometimes felt they wanted to save these children, especially when it seemed that no one else was truly available to care for them.

Annie was one such child.* She had been in two prior foster placements when she came to our clinic at age 5. Annie was an appealing child who had been in her current foster care for half a year when her caseworker referred her for therapy. Annie had witnessed repeated violence in her family of origin and had numerous behavioral problems that were creating problems for her foster mother. These included frequent outbursts of anger, bedwetting, and overeating. Annie also stared into space and did not listen. At the time Annie was referred to our clinic, she was struggling to fit into her foster home, but she also kept her relationship with her mother very much alive. She talked frequently about her mother and showed intense excitement on the few occasions when her mother came to sessions.

Annie's therapist made several attempts to engage Annie's biological mother in parent-child and individual psychotherapy sessions, but Annie's mother terminated therapy on her own. The therapist's initial efforts to engage Annie's foster mother in dyadic therapy also failed. Annie's foster mother, Ms. B, made it clear that she had no time for dyadic therapy since she had taken Annie in only on a "temporary basis." Ms. B was interested, however, in obtaining advice on Annie's behavior and so her therapist contacted her on a weekly basis to provide guidance. Annie's therapist arranged to see Annie in individual play therapy since she had a clear need for a consistent, reliable relationship.

Given her history of repeated placements, Annie's therapist was determined from the outset that she would become a "rock-solid" secure base for Annie. She saw Annie twice a week in individual therapy sessions and had weekly consultations with her foster mother. However, she soon began assuming other roles to help Annie achieve some sense of security and permanency. If Annie's ride did not show up, the therapist called a cab company to make sure that she arrived for every session. If Annie had a difficult week, the therapist extended the length of her sessions. When holidays came, the therapist prepared special celebrations to create a sense of ritual and continuity in Annie's life. Annie's therapist also contacted Annie's school on a weekly basis to help

at a glance

- Since 1998, the Parenting Assessment Team at the University of Illinois at Chicago offers treatment to mothers with chronic mental illness, foster parents, and their children.
- Young children who are open, needy, and affectionate and children who are emotionally remote and rejecting evoke intense feelings in therapists.
- Reflective supervision and team meetings can help therapists move beyond impasses and establish more genuine therapeutic relationships.

*To ensure confidentiality, the case examples we describe are constructed from diverse clinical experiences

her teachers deal Annie's emotional outbursts and poor coping skills. When court dates came up, the therapist inevitably sat in court waiting rooms to make sure the judge and attorneys knew about Annie's needs. Annie's therapist was scheduled to see Annie 2 hours each week, but she soon began to spend many more hours each week in consultation, case management, and advocacy.

Team members began to ask whether Annie's therapist was going too far in trying to meet Annie's need for security. On the one hand, members of our team could see that Annie was thriving in her therapist's care. On the other hand, there was the danger that her therapist was offering more than she could realistically give, especially in light of the fact that she had many other families in treatment. What gave Annie such power over her therapist that she was willing to spend an almost inordinate amount of time to ensure that Annie experienced enough security to cope effectively with the uncertainties of life beyond it?

Annie's therapist experienced the beginning stages of therapy with Annie as painful. On the one hand, she could see how Annie's history of maltreatment and separations contributed to her initial rejecting and distant manner. At the same time, Annie felt easily rejected and became uncontrollably angry if even the smallest limits were set in therapy. Her therapist often wondered whether Annie would ever trust.

Given her initial resistance, Annie's therapist was surprised when a meaningful relationship began to form. During this phase of therapy, Annie's needs for affection and security became overt and strong. As her therapist remarked, "Annie began to need constant physical contact during sessions. Whereas before she screamed in anger and pushed me away, she now clung to me often for long periods of time. Sometimes she leapt from chairs into my arms or crawled into my lap and slept."

In this phase of therapy, Annie began to use her therapist as a safe and secure base. When she arrived for sessions, her face quickly lit up when she saw her therapist, and she would run directly into her arms. She began to turn consistently to her therapist for protection. She seemed to remember every word her therapist said and clung to them like beloved objects.

In Annie's case, the pull to fill Annie's needs for a parent was particularly strong since her biological mother was absent. Moreover, her foster mother was not truly available to meet her many needs. Annie's growing feelings for her therapist and her need for the love and security only reinforced her therapist's involvement.

Annie soon began to fantasize about moving in with her therapist. In sessions, Annie began talking about the therapist's house and what it would be like to live there. The therapist experienced these inquiries as intensely painful. She later explained: "Annie needed a responsive caregiver even more than she needed a therapist. On some level, I sensed that I could fulfill this role myself if I wanted to do so. I wondered what kind of person I was to reject a vulnerable, needy, and affectionate child who has nowhere to go."

Although Annie's therapist did not share Annie's fantasies of living together, she did experience a pervasive wish to find her a perfect home. At times the therapist thought that, by doing even more each week, she might also be able to erase the harsh realities of Annie's life. As her wishes to find the perfect parent to adopt Annie grew stronger, Annie's therapist acknowledged for the first time in supervision just how much despair and helplessness she herself was feeling about Annie's situation. The therapist also recognized that she was sometimes overwhelmed by the intensity of Annie's needs.

It was clear from the onset that the therapist needed to remain involved until she could be reasonably assured that Annie was in a safe environment that would allow her the possibility of forming a meaningful relationship with a parental figure. In the interim, Annie needed a stable, caring person to respond to her needs. But Annie's therapist was also becoming overwhelmed. With no end in sight, she could not continue to spend numerous hours each week in case management, consultation, and advocacy.

Acknowledging the intensity of her feelings helped the therapist to explore other venues of help for Annie. Originally, Annie's foster mother did not want to come in for therapy as she viewed Annie only as a temporary child. Change did not come quickly, but over time, Ms. B came to reveal that she held Annie at bay, because she herself was also afraid of losing her. The therapist began working with Ms. B to build this fragile relationship.

Team members later wondered whether Annie's therapist should have worked more persistently with the foster mother from the beginning. However, by first focusing on Annie alone, the therapist was able to help her learn more about trusting, sensitive relationships and to open her working model to the possibility of reliable care.

Seeing the resulting changes in Annie may, in turn, have helped her foster mother feel that she could make a connection. Annie's foster mother seemed to gain more trust in therapists by watching how Annie reacted to her. With older children, it is sometimes possible or even preferable to start with the child alone and to work on the child's internal model of relationships. With infants and toddlers, however, caregivers are typically part of the therapy throughout. The impulse to save a particular child can still surface, however, if the available choices of caregivers seem inadequate. Our team's experience reinforced our belief that therapists are not there to try to replace caregivers, but to help children and caregivers become more emotionally available to one another. In Annie's case, the therapist ultimately became a secure base for the dyad, rather than for just Annie.

Emotionally Remote and Rejecting Children

Members of our team have seen many young children who have, at best, tenuous attachment bonds with others. These children may present as emotionally distant in therapy and may repeatedly reject attempts to engage them.

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Although he was only 3 years old when we saw him, Kenyada was already exceptionally hard to reach emotionally. Kenyada had been removed from his home when he was 7 months old after his older sister died in his mother's care. When Kenyada was referred to our clinic, he had been in no less than four different homes. During the 1-year period that Kenyada was seen in our clinic, visits with his mother were, at best, sporadic and her parental rights were in the process of being terminated. Kenyada had recently been placed in a temporary foster home until a more permanent placement could be found. As a result, the therapist initially worked with Kenyada alone, although she later worked intensely with his foster mother to help her better understand his behavior and feelings. Central goals of the individual work with Kenyada were to help him establish a meaningful relationship with his therapist and to aid him in coping with the many changes he was going through.

Establishing a secure therapeutic relationship with Kenyada was a formidable challenge. Early on, Kenyada's therapist began to feel defeated by the sparse responses that he gave to her attention. His lack of interest in his therapist was pervasive. He failed to look at his therapist, never said her name, and could hardly bear to sit with her in the therapy room for more than 5 minutes. Kenyada also lacked interest in himself. His gait was so quiet that he often seemed invisible to the therapist. If he accidentally hurt himself, he never cried and denied that he had any pain. He strongly ignored any concerns that the therapist showed.

Given his past history of disruptive care and abuse, his therapist had expected slow progress in therapy. However, when, after several months of work, Kenyada continued to ignore her careful and repeated attempts to help him feel safe enough to let down his powerful defenses, she began to experience a deep sense of failure. In the typical way that unanalyzed countertransference reactions become enacted, the therapist began to repeat, in therapy, Kenyada's own deep sense of numbness and remoteness. How did this numbness begin and how did we respond as a team?

In Kenyada's case, therapy started out on a hopeful note, as he appeared delighted to have individual attention from a caring and interested therapist. After a short time, however, it became apparent that Kenyada's initial cheerfulness and cooperation with his therapist was not unique. He was more prone to approach strangers and unfamiliar people than his therapist. His therapist expressed her feelings at the time in the following way: "If I redirected him to come to therapy, he subtly or very overtly let me know that he wanted nothing to do with me. At the same time, letting him return to the waiting room also had dangers. He ran to anyone and everyone in sight and hugged them. Without proper supervision, I began to worry whether his indiscriminate friendliness could have dangerous consequences for him."

At times, Kenyada's therapist felt embarrassed when he refused to come to therapy, preferring instead to stay with strangers in the waiting room. What might other therapists or clients think about her abilities? On some occasions, the therapist began to question her own therapeutic skills. Did she really know how to reach him? The therapist also began to feel hurt, especially when the consistent message to her seemed to be "You are not special; your efforts to connect with me are meaningless." As the therapist noted: "Kenyada was nobody's child, and I was a nobody, too."

Without consciously realizing what was happening, Kenyada's therapist subtly began to distance herself emotionally from Kenyada. Interactions in therapy became less lively and more rote. On the other hand, the therapist sometimes worked harder to strive for Kenyada's affection, becoming more lenient with rules and more compliant with his demands. It was as if gaining his favor could symbolically certify her skills. Ultimately, Kenyada's therapist came to realize that her motivation to gain his approval was leading to a relationship that was inauthentic. Kenyada's therapist recognized her countertransference feelings when she began to think of reducing the frequency of sessions and rationalized why fewer sessions would be clinically advantageous.

To work effectively with a child who rejects, a therapist needs knowledge, perspective, and support. Reflective supervision, regular and in-the-moment discussions with astute colleagues on the treatment team, and continuing study can all lead to great empathy, self awareness, and insight. A therapist's perspective on a child's rejecting behavior can shift once she understands that this behavior reflects powerful defenses against the emotional closeness she feels toward the therapist. Without any past experience of a consistent, responsive attachment figure, children may behave in ways to deflect the threat that an emotional connection may pose. A child's failure to express emotion may also be due to deep fears of further rejection and humiliation (Bowlby, 1988).

Kenyada's therapist was challenged both in individual supervision and in team meetings about her growing conviction that fewer sessions would be clinically advantageous. The therapist responded by revealing what a powerful impact Kenyada's rejection was having on her as a therapist and as a person. Kenyada's withdrawn and rejecting behavior may have made it easier for her to believe that she could not help him. While revealing how discouraged she had become, Kenyada's therapist also shared her deep concerns for Kenyada's well being.

Through reflective supervision and team discussions, Kenyada's therapist began to shift from a position of defeat to one of exploration and understanding. With increased understanding and perspective, she was better able to tolerate the high levels of rejection that she was experiencing. Her ability to tolerate the rejection, coupled with her growing understanding of Kenyada's defenses, began to change the tone of therapy in the next months. The therapist began to actively counter Kenyada's attitude of hopelessness and despair with an understanding and belief that she could reach him emotionally.

Although Kenyada continued to show rejecting behavior, he showed small changes. He stayed in sessions for longer periods of time and began to look quietly at the therapist. Small gestures indicated that something was changing internally in Kenyada. For instance, Kenyada began turning lights on and off during sessions. In contrast to his earlier behavior, he began looking at his therapist when the lights came on, as though he were asking "are you gone or are you still there?" Once he smiled in relief when he saw her. His therapist noted how good it feels to know someone is there when it is dark. In doing this, she began to convey to Kenyada her understanding of his feelings of abandonment and his need to know that someone was there for him. With this, she also communicated that the expression of his need for others could be met with a comforting and sympathetic response. The tone of therapy slowly began to change.

Some months later, Kenyada called his therapist by her first name. It is hard to describe just what it was like when he first said her name, but his therapist was deeply affected because he imbued her name with meaning.

Conclusion

We have described some intense countertransference reactions that members of our team experienced while treating two young children who had been in foster care for a prolonged period of time. The frequent disruptions in care and the past maltreatment that these young children had experienced in infancy and early childhood had exerted a powerful influence on their expectations and beliefs about themselves and others. Annie's needs for attachment were constantly activated at high levels. She had a highly fragile sense of self and needed almost constant touch and reassurance from her therapist to feel safe and whole. Kenyada had cut himself off almost completely from his feelings. He no longer experienced pain, no longer believed that anyone cared for him, and showed little interest in himself.

In their attempts to provide a secure, sensitive, and caring base to these children, the therapists began to unwittingly mirror the children's expectations about themselves and others. Annie's therapist strove to be the responsive, empathetic, and available person that Annie needed, but soon began to fill the role of a primary attachment figure to meet Annie's deep yearning for affection and care. She began investing an inordinate amount of time in an attempt to undo the harsh realities of Annie's life and to find her a perfect home. Kenyada's therapist came to the task with a similar mindset. However, Kenyada strongly rejected his therapist and hardly recognized her as an individual. The therapist began to mirror Kenyada's deeply ingrained belief that no one cared about him and that no one would ever be available to meet his needs. As a result, the therapist began to seriously doubt that she would ever be able to establish a meaningful relationship with Kenyada.

It is noteworthy that both Annie and Kenyada had, at best, tenuous attachment relationships with others. They had not only been in foster care for a prolonged period, several different adults had cared them for before they came to our clinic. In addition, their current caregivers were not available, at least initially, to give them the sense of security and permanence that they needed in their current placements. In this context, the relationship of each child with their therapist may have taken on special importance, contributing in part to the intense feelings the children's therapists experienced while working with them.

The intense feelings that Annie and Kenyada generated in their therapists led to impasses in therapy. Annie's therapist was spending increasing numbers of hours each week to change Annie's life, but she was also feeling increasingly overwhelmed by this. While she could see how Annie was thriving in her care, she also knew that she could not continue to devote hours and hours each week in therapy, case management, and advocacy. Kenyada's therapy was at an impasse because his therapist was beginning to withdraw emotionally from therapy sessions.

Joseph Sandler (1976), a British psychoanalyist, remarked that therapists become aware of their own countertransference feelings by observing their own behavior. Awareness often comes only after feelings have been carried over into action. This was the case with both Annie's and Kenyada's therapists. Annie's therapist became aware of her strong countertransference feelings only after she had begun to spend unrealistic amounts of time each week to function as a "rock solid" base for Annie. Kenyada's therapist noticed her countertransference feelings after she had decided to cut back on the number of hours she saw him in therapy. She later observed that Kenyada's withdrawn and rejecting behavior made it easier for her to believe that she could not help him.

Recognizing and understanding the powerful and formidable influences that the two children had on their therapists were critical both for moving beyond the impasses that resulted and for establishing more realistic and genuine therapeutic relationships with the children. Acknowledging and accepting their countertransference reactions provided valuable information that ultimately facilitated the therapeutic process.

Reflective supervision and team meetings often played a vital role in fostering change. These meetings offered team members a safe haven for sharing feelings and for gaining new perspective. The active sharing that resulted from the growing trust in each other increased our respect for each other, our understanding, and our ability to respond.

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Letters to the Editor

Infants, Toddlers, and Terror

To the Editor:

I always devour and completely enjoy every issue of *Zero to Three*. The December 2001/January 2002 issue is exceptional, even for your exceptional journal!! Thank you thank you for selecting the "...Terror: Supporting..." topic, for identifying the right mix of articles, and for pulling together such well-written articles. I still have goose bumps from the last one I read!

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Bridges to Literacy: Early Routines That Promote Later School Success

To the Editor:

It's a pleasure to find such a research-rich *and* accessible article by Sharon Rosenkoetter and Lauren Barton about promoting reading to babies (*Zero to Three*, February/March 2002). I think it will give an added oomph to the burgeoning national momentum to improve the reading of our school children beginning with our babies and toddlers.

After 12 years of offering the READ TO ME Program that focuses on teen mothers reading to their babies, I have accumulated anecdotal evidence that all babies love stories and all families tell stories. However, as these authors suggest, not all families have routines that include books in the lives of their very young children. Many parents are uncomfortable with books because they were not read to as children, do not speak or read English, had inadequate or poor school experiences, or do not think to use books in raising their newborns even if given gift books along with the diaper coupons by the hospital.

It seems to me the first of the authors' bridges, Relationships That Include Print, is the key and still underemphasized. Without actively engaging in books for very young children, these non-reading parents will not use books to read to their babies. My work involves a series of workshop activities so that the parents can get enormous pleasure and fun out of reading books for themselves. We expand the notion of 'reading' to include photos, cereal boxes and shop signs. And books. These parents respond with laughter and enjoyment, create books for their children, acquire a new library card and gift books, and pick up tips and insights about making the shared reading experience mutually entertaining. Activities that are fun get repeated, and shared.

Susan Straub, Director
READ TO ME Program
www.readtomeprogram.org

Publications

The Yale Child Study Center Guide to Understanding Your Child: Healthy Development from Birth to Adolescence

(2002) Linda C. Mayes, M.D., and Donald J. Cohen, M.D.

(Little, Brown and Company, Three Center Plaza, Boston, MA 02108-2084, www.twbookmark.com) $40.00.

Linda C. Mayes, a developmental pediatrician, psychoanalyst, and graduate ZERO TO THREE Fellow, is the Arnold Gesell Associate Professor of Child Psychiatry, Pediatrics, and Psychology at the Yale Child Study Center. The late Donald J. Cohen, a child and adolescent psychiatrist and psychoanalyst who directed the Yale Child Study Center from 1983 until his death in 2001, was Irving B. Harris Professor of Child Psychiatry, Pediatrics and Psychology at the Center. Mayes and Cohen write for a parent audience from three perspectives: 1) knowledge of the science of child development; 2) an appreciation of the child's point of view at particular ages and stages of development; and 3) the parents' expectations and experience of development. They observe: "All three perspectives demand equal attention. It is our aim in this book to help parents . . . find a balance among the practical, the factual, and the inner lives of yourself and your child. . . . Our aim is to empower you to both reconcile your child's individual needs with your own needs as a parent and to work out your own solutions. This is what it means for you to create your own family."

The *Guide* is organized along broad paths of children's development, beginning with a section on preparing to be a parent that describes "a multitude of family structures" and the "mental images and practical realities" that are part of "making room" for the baby. Chapters on the science of development describe how the child's physical, cognitive, and emotional development build upon the basic foundation of genes, brain, and "a feeling and imagining" mind. Chapters on physical, cognitive, and emotional development are followed by sections on "predictable bumps on the developmental path" (the arrival of a sibling, separation from parents, and dilemmas that working parents face) and "unpredictable troubles" (children's physical and mental health problems, exposure to violence, and the impact of divorce, remarriage, and death in the family).

Talking Reasonably and Responsibly About Early Brain Development: A Presentation Guide for Training

(2001) CEED (Center for Early Education and Development) and Irving B. Harris Training Center for Infant and Toddler Development, University of Minnesota

(CEED, 215 Pattee Hall, 150 Pillsbury Drive SE, Minneapolis, MN 55455, http://education.umn.edu/CEED/default1.html) $25.00.

Prepared to address myths and misunderstandings about early brain development that have accompanied intense public interest in the subject, this Guide is designed to assist in training child care providers, early childhood educators, parent educators, families, and other working in the infant/toddler field who would like to incorporate early brain development information within their trainings on other topics. The Guide was developed by a group of early childhood community leaders in Minnesota in conjunction with the University of Minnesota's Center for Early Education and Development and Irving B. Harris Training Center for Infant and Toddler Development. ZERO TO THREE Board member Megan R. Gunnar, professor at the University of Minnesota, also contributed to the guide. Four modules are included: 1) an illustrated overview of brain development; 2) how to be a savvy consumer of research about brain development or any topic; 3) an analysis of public messages about early brain development; and 3) how to integrate brain development information with child development information. (The Guide points out, for example, that "so far, what we know from early brain research reinforces, but does not change, what we already know is important for healthy child development.") The Guide includes diagrams and overheads, active learning exercises (including a 10-item, true-false Brain Quiz), handouts, a glossary of terms, and a resource list.

Children Who See Too Much: Lessons From the Child Witness to Violence Project

(2002) Betsy McAlister Groves

(Beacon Press, 25 Beacon Street, Boston, MA 02108-2892, www.beacon.org) $24.00.

The Child Witness to Violence Project's working definition of a violent event is "an action initiated by a human being that makes a child feel threatened, unsafe, or that results in harm to another person." Since 1992, the Project — founded at Boston Medical Center by Betsy McAlister Groves and reported on regularly in the pages of *Zero to Three* and at National Training Institutes — has sought to understand the effects of exposure to violence on young children's development and to use that understanding in direct clinical work with children and families, consultation and training to service providers, and collaboration with policymakers. In this volume, Groves integrates detailed accounts of clinical work with children exposed to community and family violence, findings from cognitive development research, descriptions of exemplary community programs and the federal Safe Start Initiative, and lessons learned in the process of program and policy development.

Groves offers "six steps that would make a difference": 1) Children must have steady, predictable, and loving relationships from birth; 2) Children and families must have access to a network of skillful helpers to facilitate healing from the effects of exposure to violence; 3) Adults must assume the responsibility of setting standards of respect, civility, and nonviolence for children; 4) To reduce violence in communities and homes, we must reduce poverty in the United States; 5) We must create a social climate that makes violence against women and children unacceptable; and 6) Each of us can be an advocate for children's safety and well-being.

Psychological Consultation in Parental Rights Cases

(1999) Frank J. Dyer

(The Guilford Press, 72 Spring Street, New York, NY 10012, www.guilford.com) $35.00.

Psychologist Frank Dyer served as chair of the New Jersey Board of Psychological Examiners' committee to develop guidelines for psychological evaluation in child custody/visitation cases. He has written this handbook for mental health consultants as a set of guidelines for the presentation of scientific evidence in termination of parental rights cases. Dyer notes that in general, such cases can be viewed along two major axes: 1) the child's age; and 2) a consideration of parental fitness versus the child's attachment profile. With the passage of the Adoption and Safe Families Act, there is a de-emphasis on the child's biological ties as a criterion for deciding the child's future, and a turn toward an assessment of the birth parents' fitness and the child's attachment profile. Dyer describes his goal as guiding professionals toward a scientifically and ethically based practice in working toward termination in cases in which such action is warranted while at the same time guaranteeing birth parents due process and competent, objective assessment of their situation and that of their children. The book includes discussion of legal issues in termination of parental rights, national legislation, guidelines for assessment, standards for expert testimony, and cross-examination questions frequently posed to expert witnesses who testify concerning children's attachment to foster parents and the harmful consequences of removing children who have formed such an attachment.

Who Speaks for America's Children? The Role of Child Advocates in Public Policy

(2001) Carol J. De Vita and Rachel Mosher-Williams, Editors

(The Urban Institute Press, 2100

M Street, NW, Washington, DC 20037, www.urban.org) $36.50 plus $3 shipping and handling.

This volume begins with the premise that most child advocacy organizations in the United States have yet to mobilize the necessary level of public interest to make the welfare of children an overriding concern in every citizen's life. It suggests that groups whose primary motivation is looking out for children's interests may need to consider whether the existence of fewer child advocacy organizations could lead to better coordination, more effective advocacy, and increased, stable funding. Chapters profile the characteristics of nonprofit child advocacy organizations, examine the role of philanthropy in supporting them, describe initiatives to increase children's health care coverage and early education, and profile individual organizations, including the Children's Defense Fund, the National Association of Child Advocates, and the National Partnership for Women and Families. A chapter on building a policy voice for children describes steps in the policymaking process, effective advocacy strategies, and what it takes for nonprofit advocacy organizations to acquire and manage necessary resources.

Infants and Toddlers in Out-of-Home Care

(2000) Debby Cryer and Thelma Harms, Editors.

(Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285-0624, www.brookespublishing.com) $34.00.

This book represents a compilation of information presented and discussions that occurred at a synthesis conference on out-of-home care for infants and toddlers that was sponsored by the National Center for Early Development & Learning, funded by the Office of Educational Research and Improvement of the U.S. Department of Education. Chapters articulate the importance of appropriate caregiving during the first years of life and describe current practices and research findings in infant/toddler child care, early intervention, and health care. Contributors include, among others, James T. Bond, Judy S. DeLoache, Ellen Galinsky, Janet Gonzalez-Mena, Michael J. Guralnick, Carollee Howes, Sharon Lynn Kagan, Ellen Eliason Kisker, John M. Love, Diane Paulsell, Helen Raikes, Catherine E. Snow, and Kathryn Taaffe McLearn.

Make-Believe Games and Activities for Imaginative Play: A Book for Parents, Teachers, and the Young Children in Their Lives

(2001) Dorothy G. Singer and Jerome L. Singer

(American Psychological Association, P.O. Box 92984, Washington, DC 20090-2984, www.apa.org/books) $19.95.

The authors of this volume, co-directors of the Yale University Family Television Research and Consultation Center in the Department of Psychology, are concerned that American society is disinclined to allow young children to explore their world through play. They note that their own 30 years of research on children's imaginative play suggests not only that such play is entertaining for children, but also that it prepares them for many useful school readiness and life skills. This volume offers procedures, suggestions, exercises and games designed to help children learn how to expand their imaginations through sensory play; poems, songs, and stories; use of indoor and outdoor "make-believe places"; daily routines at home; and thoughtful television watching.

On-Line Resources

National Center for Children in Poverty: Improving the Odds for the Healthy Development of Young Children in Foster Care

http://cpmcnet.columbia.edu/dept/nccp/ProEmoPP2.html

The second policy paper in its Promoting the Emotional Well-Being of Children and Families Series, Improving the Odds was written "to be a wake-up call – to challenge communities all over the country to attend to the needs of children in or at risk of foster care placement." The authors — Sheryl Dicker, Elysa Gordon, and Jane Knitzer — focus on what government agencies, the courts, and other organizations, as well as the people who work for and with these entities, can do to improve the healthy development of young children in foster care. The first of the paper's four sections highlights the special risks that these children face. The second section presents compelling reasons to promote the physical, developmental, and emotional health of young children in foster care, followed by a section highlighting five strategies that do so. Under each strategy are descriptions of two or more programs from across the country that have put that strategy into practice. The paper finishes with descriptions of 10 action steps that states and communities are encouraged to take to promote the development of young children in foster care and to better meet the needs of their parents and foster parents.

Building Services and Systems to Support the Healthy Emotional Development of Young Children

http://cpmcnet.columbia.edu/dept/nccp/ProEmoPP1.html

This persuasive action guide informs policymakers of the importance of developing policies and practices to promote the healthy development of children at risk for poor cognitive, social, and behavioral outcomes. Authored by Jane Knitzer, deputy director of the

National Center for Children in Poverty, this monograph is the first policy paper in the Center's *Promoting the Emotional Well-Being of Children and Families* series.

Research from the past 10 years is given that supports three cost-sensitive reasons for investing in the emotional health of young children:

1. "The earliest years set the stage for lifetime emotional skills, competencies, and problems" (p. 6);
2. "Many young children are not developing the emotional skills that they will need to succeed in school and be productive members of society" (p. 8); and
3. "Achieving the national policy goal of school readiness for all children requires paying attention to early social, emotional, and behavioral challenges as well as cognitive and physical development" (p. 8).

A framework for translating research into effective systems of support is then presented. The framework is based on four goals that, together, represent a public/health/mental health model that emphasizes wellness promotion and early intervention but also draws on treatment strategies as needed. State, national, and community initiatives that have developed services and service delivery strategies are described, and themes common to successful initiatives are discussed. The monograph concludes with explanations of 10 recommended action steps.

The Urban Institute: Running to Keep in Place: The Continuing Evolution of Our Nation's Child Welfare System

http://newfederalism.urban.org/html/op54/occa54.html

This new report from The Urban Institute analyzes interviews conducted in 1999 with child welfare administrators, front-line workers, and advocates in 12 states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, New Jersey, New York, Texas, Washington, and Wisconsin) in order to document how welfare reform and other changes may be affecting child welfare agencies. The interviews were part of the Institute's Assessing the New Federalism Project, a multiyear effort designed to analyze the devolution of responsibility for social programs from the federal government to the states. Interviewees, as in 1997, expressed significant concerns about the quality and capacity of the child welfare system. The report discusses the crises and criticism that many child welfare systems face and how the system continues to be largely reactive to, and driven by, these crises and criticism as well as changes in leadership and mission. It also discusses ways that both federal and state governments are seeking to improve the child welfare system – for example, increasing oversight and making agencies more accountable for outcomes – as well the effect on the system of its own resource capacity and the resource capacity of other systems. Finally, the effect of crises, criticism, and system changes on child welfare workers and on the nature of their job, including workload, are discussed.

The Children's Bureau Administration for Children and Families U.S. Department of Health and Human Services Adoption and Foster Care Analysis and Reporting System (AFCARS) Reports

http://www.acf.dhhs.gov/programs/cb/dis/afcars/cwstats.html

State child welfare agencies report to the AFCARS system on children who have been adopted under their auspices and on the children in their foster care system. This Federal system processes the state data and develops reports to assist the Children's Bureau in program management, policy development, monitoring of state programs, budget projections, and trend analyses. AFCARS Reports Nos. 1 through 6 are available on-line and provide national figures for the population of children in foster care (estimated at 556,000 as of September 30, 2001) and varied demographics for that population. State specific data also is available in reports on the Web site.

National Center for Resource Family Support Casey Family Programs

http://www.casey.org/cnc/index.htm

Reorganized in February 2002, this Web site offers a wealth of information – fact sheets, state contacts, handbooks, toolkits, policy analysis, resource lists – for resource families and the child welfare professionals who work with them. ("Resource families" are defined as "foster families, adoptive families and kinship care families who care for children when biological parents cannot do so.")

The full text of a variety of publications is available – such as three new documents on issues related to siblings in foster care; *Partners: Working with the Business Community to Recruit Resource Families* (2002); *Dual Licensure of Foster and Adoptive Families: Evolving Best Practice* (May 2001), and *Foster Care Today* (2001) – as well as "Quick Facts" pages on issues such as foster parenting, youth in transition from foster care, and relevant statistics. The State Contacts Web page provides state-by-state information for public foster care and adoption agencies, adoption exchange, and foster parents association. Information also is available on-line about The Foster Family Assessment Project's work on developing the Casey Foster Applicant Inventory (CFAI), a new tool designed to assist social workers and potential foster parents to identify foster family applicants' strengths and service needs, in order to facilitate successful placements, enhance foster family satisfaction, and increase foster family retention.

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Coalition addresses the mental health needs of children in foster care

Marilyn Benoit, M.D., President of the **American Academy of Child and Adolescent Psychiatry (AACAP)** has dedicated time and resources of her AACAP Presidential Initiative (Oct. 2001 – October 2003) to focus attention on the **mental health needs of foster care children and their families**. The Child Welfare League of America (CWLA) welcomed her in this effort, and the two organizations have now involved more than 30 public and private organizations, including the **National Institute of Mental Health (NIMH), Substance Abuse Mental Health Services Administration (SAMHSA), American Bar Association, Black Administrators in Child Welfare, Federation of Families for Children's Mental Health, National Foster Parent Association,** ZERO TO THREE, and other stakeholders that are dedicated to the health and well-being of children in foster care.

A preliminary goal for the participants was the development of policies that will guide the effort to increase mental health services to children and families in the foster care system. Two policy statements, one that sets the values and principles of mental health services, and another that addresses screening and assessment for mental illnesses, have been released. A third policy statement will give specific direction to the mental health needs of children in the birth to 3 age range, which includes 25% of the foster care population. The policy statements will also contribute to the creation of an assessment tool kit that relevant agenes can use to provide services to children with emotional disorders who are entering or are part of the foster care system. The fourth mental health foster care conference is scheduled for June 28, in Washington. For more information, e-mail or call Catherine Nastro at AACAP, cnastro@aacap.org or (202) 966-7300, ext. 128.

Idaho passes legislation to protect the rights of parents with disabilities and their children.

In the the June/July 2001 issue of *Zero to Three*, Megan Kirshbaum, 1999-2000 ZERO TO THREE Mid-Career Fellow, wrote "Tales from the Frontlines: A Practitioner's First Experiences in Public Policy Advocacy." She described how providing technical assistance, based on Through the Looking Glass' clinical and research expertise, led to her unanticipated involvement in the passage of legislation changing Medicaid policy in California so that it covers funding of baby care adaptations for parents with disabilities. The article also mentioned a similar provision of technical assistance and training regarding parents with disabilities which supported the development of state legislation in Idaho.

Megan is excited to report that the Idaho legislation has also just passed unanimously, due to the hard work of a committee of legislators and disability leaders in that state. The Idaho legislation is a model for legal reform protecting the rights of parents with disabilities and their children in child custody in divorce, separation, termination of parental rights, adoption, and guardianship. For more information about parents with disabilities and their children see www.lookingglass.org.

The **David and Lucile Packard Foundation** has awarded a grant of $420,000 to ZERO TO THREE for continuing support for its **Center for Program Excellence**. The Center provides resources, training, and technical assistance to directors and key management staff in child care and infant/family programs across the country.

The ZERO TO THREE Center for Program Excellence also was recently awarded a 1-year grant by the **District of Columbia Early Intervention Program** to provide training and technical assistance services to early intervention professionals, paraprofessionals, volunteers, and families of infants and toddlers with special needs in the D.C. area. The project, which will run for 1 year beginning in Spring 2002, is centered around monthly 2½-hour training workshops. These trainings, each of which will include a parent co-facilitator, will address three key areas: family-centered services; cultural competency; and providing services in natural environment. In addition, project director Monimalika Day, Ph.D., will provide follow-up phone consultation to participants to discuss the topics presented in trainings and to support the transition from the theory to practice. Finally, Dr. Day and others from ZERO TO THREE and the Center will be responsible for organizing an annual conference for approximately 200 early intervention staff in the D.C. area. Additional funding for the ZERO TO THREE Center for Program Excellence is provided by the AT&T Family Care Development Fund.

UPCOMING ISSUES

- **June/July 2002**—Perinatal Mental Health: Linda Mayes, Neill Epperson, and Arietta Slade, of the Yale University School of Medicine, will be Guest Editors.
- **August/September 2002**—The Musical Lives of Babies and Families: Lori Custodero of Teachers' College, Columbia University, will be Guest Editor.
- **October/November 2002**—The Role of Paraprofessionals in Early Childhood Intervention: Sydney Hans and Jon Korfmacher will be Guest Editors.

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The Sally Provence Award for Excellence

* Recognizes, in alternate years, individuals and service programs whose work with infants, toddlers, families, and communities demonstrates the qualities that Dr. Provence considered essential to effective practice.
* Honors Sally Provence, M.D., a pioneer in the infant/family field and a founding member and president of ZERO TO THREE. As a pediatrician and mental health clinician at the Yale Child Study Center, she called attention to qualities in both individuals and programs that are likely to lead to success in supporting the development of very young children:
  - an abiding curiosity about the meaning of behavior in very young children and their families;
  - a sturdy conceptual framework for understanding developmental issues and problems in children and parents that also serves as the foundation for services;
  - continuity and individualization of respectful, trustworthy care; and
  - training and ongoing support for all professionals who touch the lives of babies, toddlers, and families.

Eligibility

The 2002 award will be made to a program.

Nomination process

Programs can nominate themselves or be nominated by others. In the latter case, the nominator will determine the program's willingness to be considered, provide contact information, and request that ZERO TO THREE send the program an application.

Selection process

Programs wishing to be considered for the award will complete an application that focuses on the way in which the four program characteristics, listed above, are brought to bear on services to a particular child and parent/family. The application, due August 1, 2002, includes questions for both program staff and parent/family members to answer. An Awards Committee will review all applications and notify applicants by September 15.

Recognition

The award will be presented at the December 4, 2002, awards luncheon at ZERO TO THREE's National Training Institute in Washington, D.C. Travel, hotel, and registration costs for a representative of the recognized program will be complimentary. The Zero to Three journal and the organization's Web site will also feature the program.

For more information

For an application, please e-mail Bill McCall, Program Associate, at b.mccall@zerotothree.org, or call him at (202) 638-1144, ext. 665.

The Editorial Mission of the *Zero to Three* Bulletin

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler and family field.

The Mission of ZERO TO THREE: National Center for Infants, Toddlers and Families

ZERO TO THREE is a national nonprofit whose mission is to promote the healthy social, emotional and intellectual development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

www.zerotothree.org

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